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ABSTRACT

Following an introductory survey of the course, this modular drug abuse trainer's manual contains all course-specified materials. These materials are: the course goals and objectives; time/activity sheets; trainer guidelines, process notes, and exercise instructions; detailed lectures and supplementary information. The time/activity sheets contain the training schedule with time allocations, training tasks with the materials and equipment needed, training activities that specify expected trainer and trainee behaviors, and logistical details. Actual course topic areas are: historical evolution of drug use; types of drugs; drug effects; alcohol and marihuana; social and legal responses to drug use; treatment efforts; drug myths; drug dependence; the evolution of polydrug abuse; and the roles of families, schools, communities and peer groups related to drug abuse prevention. Additional items discuss feedback and evaluation by trainers. (LS)

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Facts About Drug Abuse

Trainer Manual

U.S. DEPARTMENT OF HEALTH,
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COURSE OVERVIEW

PURPOSE

To identify the inaccurate images and unsound assumptions about substances, abuse, and use that can impede progress in dealing with substance abuse; to examine the phenomenon of drug addiction; to consider the social and historical development of substance use in this country; to provide an accurate description of those psychoactive drugs with a potential for abuse, and to place their relative hazards in perspective; to identify methods of drug abuse treatment; and to explore the role of family, school, community, and peer groups in drug abuse prevention efforts.

OBJECTIVES

Using the information presented in the *Facts About Drug Abuse* course, at the end of this course, and without the aid of notes, the participants will be able to—

- identify at least three elements basic to the use of any drug;
- identify at least four different perspectives for perceiving drug use;
- identify the scientific definition of a "drug;"
- identify at least three levels of dosage for every drug discussed;
- identify at least four stages in the history of the use of drugs that lead to dependence;
- identify at least three main features of addiction;
- identify at least four generating factors indicating the causes and conditions related to the drug-taking process;
- identify at least three reactions to consumption of sedative hypnotics (particularly alcohol) that can lead to convulsions;
- identify at least three reactions to consumption of sedative hypnotics (particularly alcohol) that can lead to coma;
- identify at least one advantage and one disadvantage of each of these treatment methods:
    - methadone maintenance
    - therapeutic communities
    - extended group psychotherapy;
- identify at least four major strategies of prevention that correspond to drug-individual-context variables;
- identify at least three principles that can determine the effectiveness of information or communication related to drug abuse prevention;
- identify at least one key to the effectiveness of alternatives as a deterrent to drug use;
- identify at least four roles a family can play as a deterrent to drug use;
- identify at least one role a school can play as a deterrent to drug use;
- identify at least one role a peer group can play as a deterrent to drug use;
- identify at least two directions the Federal government is taking to prevent the use of drugs;

(Continued on inside back cover)

FACTS ABOUT DRUG ABUSE

Trainer's Manual

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November 1977

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There are not enough words to express my appreciation to Ralph Larson, Steve Glenn, Joel Warner, Elaine Casey, Weebie Flagg, Linda Hamner, Sharon Schultz, Gini Burchett, and Anita Smith, whose energy, support, and assistance were invaluable from the beginning of this undertaking.

I would like to dedicate this course to my sons who shared their views about "dope" with me.

William E. Link

PREFACE

One of the conceptual difficulties of health planners and people concerned with health policy has been the difficulty of defining "good health" in a way that provides a clear basis for social action. Some definitions emphasize the concept of "absence of disease." Other definitions are concerned with the positive promotion of quality of life; others combine both concepts. Yet there is no general agreement today on what constitutes "good health." This same dilemma carries over to the discussion of "drug abuse." Not only is there a question of what constitutes good treatment, but there has been an ambivalence as to the meaning of "drug abuse."

Historically, there have been a variety of definitions ascribed to the term "drug abuse." Some schools of thought use the classical public health approach; some use definitions that fit other social and behavioral models. Some people want to limit the discussion to the so-called "demand" activities--which center primarily on the development and delivery of health and social services. Still others want to include all activities designed to reduce drug abuse--including law enforcement efforts and approaches designed to regulate the availability of drugs. While supply reduction efforts are an important aspect of an overall prevention strategy--and companion legal control approaches to tobacco and alcohol (such as taxes, ABC laws, minimum ages for legal drinking and smoking, controlled sales points,etc.) are essential for the more comprehensive discussion of drug abuse--this course will focus on those factors that attempt to influence behavior and attitude, and whose compelling force is not legal sanction. While definitions are important, we are less concerned with them than we are with the results of these efforts, which are to prevent, delay, and reduce the use and abuse of a variety of drugs.

We recognize that most people in the United States use or have used psychoactive substances. The latest national household survey on the use of psychoactive drugs (NIDA, 1976) notes that 50 percent of youths age 12-17 and 67 percent of all adults have smoked cigarettes; 55 percent of those youths and 82 percent of adults have used alcohol; 22 percent of the youths, and 21 percent of adults have used marihuana. These rates of use, especially with alcohol and tobacco, are associated with a high casualty rate to society--which we want to reduce. While the nonmedical use of psychotropic drugs (sedatives, tranquilizers, stimulants) is lower--11 percent of youths and 15 percent of adults--the consequences associated with such use are often costly to society, due to both drug overdose reactions, and a range of effects associated with intoxification--including automobile mishaps, work accidents, and deteriorated interpersonal relationships. Finally, while only one percent of the adults and one-half of one percent of the youths have used heroin, this use clearly is associated with high immediate social costs in terms of physical addiction, drug-related crime, broken families, adverse health consequences, and even death.

There are a variety of strategies we can employ to reduce drug casualties. First, we want to reinforce the drug-free experience. Further, we are interested in limiting the variety of drugs used, since multiple-drug use is often associated with chronic, intensive use of drugs. Finally, we are concerned about reducing the frequency of use because we believe there is a strong relationship between frequency and casualty. Consequently, our definition of drug abuse covers all of these areas.

REFERENCES

National Institute on Drug Abuse. *Nonmedical Use of Psychoactive Substances.* Washington, D.C.: Department of Health, Education and Welfare, 1976.

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INTRODUCTION

This course is a thorough revision of the course *Drug Abuse: Fundamental Facts and Insights* which was produced by the National Drug Abuse Center.

On March 22, 1973, the National Commission on Marihuana and Drug Abuse stated:

> The term (drug abuse) has no functional utility and has become no more than an arbitrary codeword for that drug use which is presently considered wrong. Continued use of this term, with its emotional overtones, will serve only to perpetuate confused public attitudes about drug-using behavior. The Commission urges that the public and its policy makers avoid such labels and focus instead on the relative risks and social consequences of various patterns of drug-taking behavior.

The present training course, in an attempt to deal with both the confusion and emotional overtones of the term "drug abuse," is titled *Facts About Drug Abuse.*

The National Drug Abuse Center realizes that the word "abuse" also elicits emotional overtones and subjective interpretations; however, it is most descriptive of the course content.

No single training course can provide all the known information about drugs or substances and the abuse of either. This *Facts About Drug Abuse* course is a basic course, designed for those who lack knowledge of the areas listed below. They are essential areas that need to be understood if one chooses to engage in drug abuse prevention, treatment, rehabilitation, drug education efforts, or simply wishes to increase knowledge of drug abuse in order to sharpen his perspective about the current drug abuse problem in this country. The topic areas that are covered in this course are:

- Historical evolution of drug use.

- Types of drugs.
- Drug effects.
- Alcohol and Marihuana.
- Social and legal responses to drug use.
- Treatment efforts.
- Drug myths.
- Drug dependence.
- Evolution of polydrug abuse.
- Roles of families, schools, communities, and peer groups related to drug abuse prevention.

TRAINING GOAL

The overriding goal of this course is to build a base of knowledge and experience that will clarify and present general information related to drugs and abuse. It is our hope that participants will be stimulated to such further knowledge from other training and education opportunities related to drug abuse.

TRAINING METHODOLOGY

The training strategy combines didactic instruction and experiential learning. Various training methods are used to make the learning process more effective: lectures, demonstrations, task-group exercises, guided group discussions, and individual reading assignments. Learning activities are designed to facilitate large-group and small-group interactions and to provide participants with an opportunity to gain knowledge and skills they can use on the job. Each module provides adequate time for new information to be presented, analyzed and applied. The evaluation methodology incorporates written objective tests, simulations, trainer self-evaluations, and participation feedback.

COURSE MATERIALS

Training materials consist of a *Trainer's Manual* and a *Resource*

Manual.

The *Trainer's Manual* contains all of the course-specified information the trainer will need:

- Goals and objectives of the course
- Time/Activity sheets that contain:
  - -Training schedule with time allocations
  - -Training tasks and the materials and equipment needed for each task
  - -Training activities that specify expected trainer and trainee behaviors
  - -Logistical details
- Trainer guidelines, process notes, and instructions for each exercise
- Detailed lectures and supplementary information

The *Resource Manual* contains the basic information that the trainer and participant should master. It includes:

- Course content
- Charts and forms used in each module
- Guidelines for task performance
- Papers, articles, and handouts related to lectures
- Bibliography and glossary

TIME REQUIRED FOR COURSE DELIVERY

The *Facts About Drug Abuse* course is composed of nine modules. The total training time is 28 hours, with approximately six hours of outside reading.

The modular organization of the course lends itself to a variety of delivery approaches. The course should be delivered in one- or two-module segments over an extended period of time, and it could be incorporated as part of a credentialing program for drug abuse program staff. For a three and one-half day delivery, the course schedule would be as follows:

COURSE SCHEDULE

DAY ONE

MODULE I - Introduction and Orientation
(1 hour, 30 minutes)

MODULE II - The "Problem" with "Drugs" and "Drug Abuse"
(3 hours)

MODULE III - The "Problem" with "Drug Addiction"
(3 hours, 15 minutes)

DAY TWO

MODULE IV - A Social and Historical Context for Understanding Substance Use in the United States
(3 hours, 30 minutes)

MODULE V - Substance Actions and Potential Hazards
(4 hours)

MODULE VI - Understanding and Overcoming Substance Dependence
(3 hours, 30 minutes)

DAY THREE

MODULE VII - Prevention and the Community, School, Family, Peers and Youth
(3 hours)

MODULE VIII - Roles and Strategies for Prevention Efforts
(2 hours, 10 minutes)

MODULE IX - Closure and Evaluation
(1 hour)

STAFF REQUIREMENTS

Three trainers are needed to conduct this course. There should be a trainer/trainee ratio of approximately one trainer for each ten participants. Optimum training group size is 30 participants.

Because the *Facts About Drug Abuse* course focuses on attitudes, values, knowledge, and skill development, it is essential that the trainers have experience as group leaders in *both* group dynamics and task-oriented training. They should:

- Be familiar with several different styles of training, with different training concepts and approaches;
- be sensitive to training concerns and issues;
- have knowledge of drug abuse problems and drug treatment modalities;
- have at least two years of experience in conducting group dynamics and task-oriented training;
- have experience in training trainers.

LEARNING CLIMATE

The trainer's behavior and attitudes are critical factors in establishing a productive learning climate. The trainer must *demonstrate* that he wants to have a responsive relationship, not merely assert that this is so. He must be aware of this throughout the course and should model behavior that reinforces the open, self-disclosing atmosphere needed to make this course a success. *Adequate time must be allotted for setting and maintaining a cooperative climate. This will consume about one-quarter of the total training time.*

A certain level of tension is useful to help participants examine their assumptions and integrate new information. If the training climate is an open and honest atmosphere where everyone feels free and responsible for his own learning, the training activities will facilitate exploration of differing points of view; this will create the moderate level of tension necessary for the course. Trainers should not prod participants to expose too much of themselves too soon; participants should be encouraged to express their thoughts and feelings when they desire and should also be allowed to be silent. Success depends on everyone's feeling free to take part actively, to comment, to criticize, to make suggestions, and to listen to one another. The trainer must be careful, however, not to exaggerate a training group's need for support. He must be supportive enough to permit the group to grow and learn, but not so supportive that he promotes overdependence.

The Relationship of Co-trainers

The relationship between co-trainers should demonstrate mutual responsibility and respect. When conflict arises based on differing points of view, the co-trainers should show through their behavior that, although differences may exist, there is a genuine appreciation and acceptance of each other that underlies all interaction.

Trainers bring to this course the result of their experiences, their beliefs, their reactions, and their feelings about themselves and their roles. Before the training begins, trainers need to examine their own and each other's attitudes about the training issues that are discussed in this course. They need to share their expectations and personal limitations; to compare their reactions to the resource papers; and to discuss how each trainer will handle delicate issues if, and when, they arise. They should explore the areas in which they feel confident and those in which they feel vulnerable.

Suggestions for Team Building

To facilitate learning and to provide the proper support for trainees, the trainers should do some "team building" before actual training begins. This team building combines planning, rehearsing, developing interpersonal relationships, and specifying certain details.

In addition to assigning tasks, practicing exercises, and rehearsing lectures, the trainers should spend some time thinking and talking about their experiences as trainers. This is a central issue in this course. Trainers should discuss how they can be supportive of each other.

Tips to Co-trainers

Trainers should keep in mind the following points both during pre-session planning and while training the course:

- The trainers' relationships set a model for the group. (Demonstrate support for each other. Switch roles when discussing different aspects and issues of the training group. When it seems appropriate, articulate your differing points of view.)
- Trainers should help each other clarify points.
- Specific, descriptive, nonblaming responses should be used.
- Whenever one trainer is in charge of an activity, the other trainers should take a supportive role, attending to group dynamics and intervening when it seems appropriate. (Avoid interrupting the other trainer except to clarify some point that seems confusing to the group.)
- Trainers should recognize that any opinion expressed in the session reflects the speaker's perception of the world.

PREPARING FOR TRAINING

It is important to follow the course as outlined. Therefore, trainers must study the materials and prepare for presentation well before the first training session.

The first page of each module is a module overview. The pages following the overview describe the training activities. The left-hand column, entitled *Time/Materials*, lists the materials needed for each activity. It is very important for the trainer to read both the *Trainer's Manual* and the *Resource Manual*. These materials should be read, digested, and mastered *before* the training activity is conducted. (The *Resource Manual* contains handouts, task instructions, forms, and papers to be used as a reference by both the trainer and the trainees.)

The right-hand column, entitled *Trainer Activities Outline*, describes the training activities that are necessary for the trainer to cover in each module. The *Trainer's Manual* contains the lectures, instructions for activities, forms, and guidelines for the trainer.

The sequence of instruction is as follows. All modules begin in the large group setting. The trainer should:

- explain the purpose of the module;
- cover the content, following the sequence of activities and using the materials provided and the methods suggested;
- summarize the module to review the main points;
- review with participants what they have learned about this module.

It is helpful to remember that the amount of time indicated for each module and topic is *approximate*. More or less time may be required or desired. While some flexibility is permissible, scheduling must allow for adequate coverage of the topics in the selected modules.

THE FIRST TRAINING SESSION

The following suggestions may be helpful:

- Review the *Trainer's Manual* and read the *Resource Manual*.
- Review the first page of each module and determine the relationship of the module to the previous module, subsequent modules, and the total course.
- Prepare course goals and schedule on newsprint.
- Be sure that all the materials are prepared, that equipment is working, and that the space needed is properly set up for the training.
- Prepare flip charts before the session. If an easel is not available, paper may be tacked or taped to the wall.

- If audio-visual equipment is used, make sure it will be available and operational when needed. Make sure that you know how to use the equipment.

- Review the sequence of activities, the points to be discussed, and materials several times before the session to become thoroughly familiar with the session and its content.

- During the presentation keep in mind the structure of the session, i.e., introduction, major points, summary.

For the presentation to be effective, the trainer must:

- remember that he is dealing with adults;

- be thoroughly familiar with the resource materials;

- prepare adequately for each module so that the course design is followed.

FEEDBACK: THE ART OF GIVING AND RECEIVING HELP*

Feedback is a way of helping another person to consider changing his behavior. It is communication to a person that gives him information about his behavior and its effect. As in a guided missile system, feedback helps an individual know whether his behavior is having the effect that he wants; it tells him whether he is "on target" as he strives to achieve his goals.

CRITERIA FOR USEFUL FEEDBACK

The giving and receiving of feedback is a skill that can be acquired. When feedback is attempted at the wrong time or given in the wrong way, the results will be useless at best-and may even be disastrous. Therefore, developing feedback skills is important. Here are some criteria of useful feedback:

- It is descriptive rather than evaluative. Good feedback focuses on what the individual did; it does not translate his behavior into a statement about what he is. "You have interrupted three people in the last half hour" is probably not something that a person really wants to hear, but is likely to be more helpful than, " You are a bad- mannered oaf."

- It focuses on the feelings generated in the person who has experienced the behavior and who is offering the feedback. "When you interrupt me I feel frustrated," gives the individual clear information about the effect of his behavior, while at the same time leaving him free to decide what he wants to do about that effect.

- It is specific rather than general. For example, it is probably more useful to learn that you "talk too much" than to have someone describe you as "dominating."

---

*Cyril R. Mill. This material is taken from the *Reading Book*, 1972 Edition, of the NTL Institute for Applied Behavioral Science, associated with the National Education Association.

- It is directed toward behavior that the receiver can do something about. Frustration is increased when a person is reminded of some shortcoming over which he has no control.

- It is solicited rather than imposed. Feedback is most useful when the receiver feels that he needs and wants it, when he himself asks a question that those observing him can answer.

- It is well-timed. In general, feedback is most useful when given as soon as possible after the questioned behavior. Timing depends on the receiver's readiness to hear the feedback, the support available from others, and so on.

- It is checked to ensure clear communication. One way of doing this is to have the receiver try to rephrase the feedback in question to see whether the receiver's version corresponds to what the sender meant.

- Both giver and receiver have an opportunity to check its accuracy with others in the group. Thus, the receiver will know whether this is one person's impression or an impression shared by others.

- It should not be given primarily to "dump" or "unload" on another. If you feel you have to say this to the other person, ask yourself who it is you are trying to "help."

- Feedback does not ask "Why?" It focuses on one's behavior and the reactions to that behavior. To theorize about or ask why a person does a certain thing is to plumb the depths of motivation and, perhaps, of the unconscious. Avoiding the "whys" will help one to avoid the possible damage that can result from playing amateur psychologist.

Given the premise that properly-given feedback can be a fine way to learn about oneself, what are some reasons that we resist it? For one thing, it is hard to admit our faults to ourselves. It is even harder to admit them to someone else. We are not sure that the other person can be trusted or that his observations are valid. We may be afraid of learning what others think of us; we often expect to hear only negative opinions about ourselves, tending to overlook our positive qualities.

There's a second side to this exchange: it is not always easy to give feedback to others. Most of us like to give advice. Doing so suggests that we are competent and important. We get caught up in a "telling" role easily enough without testing whether our advice is appropriate to the issue or to the abilities, the fears, or the powers of the person we are trying to help.

If a person whom we are trying to help becomes defensive, we may try to argue or pressure him. Defensiveness or denial on the part of the receiver is a clear indication that we are going about trying to be helpful in the wrong way; our timing may be off or we may be simply mistaken about his behavior; but, in any case, it is best to desist until we can reevaluate the situation. If we respond to the receiver's resistance with more pressure, resistance will only increase.

Feedback takes into account the needs of both the receiver and the giver. Positive feedback is welcomed by the receiver when it is genuine. If feedback is given in a training setting, under the conditions described here, it can become one of the primary means of learning about the self.

TRAINER QUESTIONNAIRE

The Trainer Questionnaire is designed to help the trainers examine the dynamics present in the co-training situation. Trainers should use it to prepare to train the course and also to examine the dynamics occurring during each day's training.

For each module trainers should ask themselves:

- How am I feeling about myself right now ?
- How do I feel about my co-trainers and our relationship?

With regard to the participants, the trainer should consider the questions in the following sections.

WHAT TO LOOK FOR IN GROUPS

All human interactions have two major ingredients: content and process. The first deals with the subject matter or the task with which the group is working. In most interactions, the main focus is on the content. The second ingredient, process, is concerned with what is happening between and to group members while the group is working. The group process, as it emerges in this course, encompasses tone, atmosphere, influence, participation, styles of influence, leadership struggles, conflict, competition, and cooperation. In most interactions, very little attention is paid to process, even when it is the major cause of ineffective group action. Sensitivity to group process will better enable trainers to diagnose group problems early and deal with them more effectively, and will enable participants to be more effective participants. Below are some guidelines to help trainers analyze group behavior.

Participation

Verbal participation is one indication of involvement. Trainers should look for differing amounts of participation within the group.*

- Who participates more than others? Who participates less?
- Do you see any shift in participation, i.e., frequent participators becoming quiet, infrequent participators

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* Adapted from *The 1972 Annual Handbook for Group Facilitators*, J.W. Pfeiffer and J.C. Jones, Eds. La Jolla, Ca.: University Associates Publishers, Inc., 1972, 21-26.

suddenly becoming talkative? Do you see any possible reason for this in the group's interaction?

- Does anyone make contributions that receive no response or recognition? What effect does this have on the member?

- How are those who remain silent treated? How is their silence interpreted (consent, disagreement, disinterest, fear, etc.)?

- Who talks to whom? Do you see any reason for this in the group's interactions?

- Who keeps the discussion going? Why? Do you see any reason for this in the group's interactions?

Influence

Influence and participation are not the same. Some people may speak very little, yet they capture the attention of the whole group. Others may talk a lot but are generally not listened to by other members.

- Which members seem to have a great deal of influence? Which members have little influence? Is there any shifting of influence?

- Do you see any rivalry in the group? Is there a struggle for leadership? What effect does it have on other group members?

Styles of Influence

Influence can take many forms. It can be positive or negative; it can enlist the support or cooperation of others or alienate them. How a person attempts to influence another may be the determining factor in the other's receptivity. There are at least four styles of influence that frequently emerge in groups:

- *Autocratic.* Does anyone attempt to impose his will or values on others or try to push them to support his decisions? Who evaluates or passes judgment on other group members? Do any members block action when it is not moving in the direction they desire? Who pushes to "get the group organized?"

- *Peacemaking.* Who eagerly supports others decisions? Does anyone consistently try to avoid conflict or having unpleasant feelings being expressed? Is any member deferential toward other group members (thus giving others power)? Do any members avoid giving negative feedback, i.e., will they be honest only when they have positive feedback to give?

- *Laissez-faire.* Are any group members withdrawn and uninvolved? Does any group member go along with group decisions without seeming to commit himself one way or the other? Who does not initiate activity, or participates mechanically and only in response to another member's question?

- *Democratic.* Does anyone try to include everyone in a group discussion or decision? Who expresses his feelings and opinions openly and directly without evaluating or judging others? When feelings run high and tensions mount, which members attempt to deal with the conflict?

Decision-making Procedures

Many decisions are made in groups before full consideration has been given to the effects these decisions will have on other members. Some people try to impose their decisions on the group, while others want all members to participate or share in the decisions that are made.

- Does anyone make a decision and carry it out without checking with other group members? (For example, does anyone decide on the topic to be discussed and immediately begin to talk about it?) What effect does this have on others?

- Who supports other members' suggestions or decisions? Does this support result in two of the members' deciding the topic or activity for the group? How does this affect others?

- Is there any evidence of a majority's pushing a decision through over other members' objections? Do they call for a vote?

- Is there any attempt to get all members to agree on a decision? What effect does this seem to have on the group?

Membership

A major concern for group members is the degree to which they are accepted by the group. Different patterns of interaction may develop in the group that gives clues to the degree and kind of membership.

- Are there any subgroups? (Two or three members may join together for a period of time during which they consistently agree and support each other. Or several members may consistently disagree and oppose one another.)

- Do some people seem to be "outside" the group? Are some "in?" How are those "outside" treated?

Feelings

During any group discussion, feelings frequently are generated by the interactions between members. Although these feelings are discussed rarely, the tone of voice, facial expressions, gestures, and many other forms of nonverbal cues can help observers understand what participants are feeling.

- What signs of feelings do you observe in group members (anger, irritation, frustration, warmth, affection, excitement, boredom, defensiveness, competitiveness, etc.)?

- Do you see any attempts by group members to block the expression of feelings, particularly painful feelings? How is this done? Does anyone do this consistently?

Task Functions

There are certain functions that should be carried out in order to get the job done. The trainers will improve their understanding of the process if they can see how these functions are accomplished.

- Does anyone ask for or suggest the best way tp proceed or to tackle a problem?

- Does anyone attempt to summarize what has been covered or what has been going on in the group?

- Is there any giving or asking for facts, ideas, opinions, feelings, feedback, or searching for alternatives?

Maintenance Functions

These functions are important to the morale of the group. Their performance (or the lack thereof) can maintain or destroy good and harmonious working relationships among the members. When carried out properly, these functions can enhance other member's ability to contribute maximally.

- Who helps others get into the discussion?
- Who cuts off others or interrupts them?
- Who helps keep the group on the topic? Does anyone try to change the subject?
- How well are members getting their ideas across? Are some members preoccupied and non-listening? Are there any attempts by group members to help others clarify their ideas?
- How are ideas rejected? How do members react when their ideas are not accepted? Do members attempt to support others when they reject their ideas?

Group Atmosphere

The way a group works together creates a discernible atmosphere; trying to describe this atmosphere will give the trainer some insight into what people do and don't like about the training environment.

- Are there group members who seem to prefer a friendly, congenial atmosphere? Is there any attempt to suppress conflict or unpleasant feelings?
- Do any members seem to prefer an atmosphere of conflict and disagreements? Do they provoke or annoy others?
- Do people seem involved and interested? What is the atmosphere like?
- Are certain topics avoided in the group (e.g., sex, talk about immediate feelings in the group, discussing the leader's behavior, etc.)? Who seems to reinforce this avoidance? How?

- Are group members overly nice or polite to each other? Are only pleasurable feelings expressed? Do members agree with each other too readily? What happens when members disagree?

- Do you see norms operating about participation or the kinds of questions that are allowed (e.g., "If I talk, you must talk"; or "If I tell my problems you have to tell yours.") Do members feel free to ask each other about their feelings, or are questions restricted to intellectual topics or events outside of the group?

MODULE I

INTRODUCTION AND ORIENTATION

MODULE I: INTRODUCTION AND ORIENTATION

PERSPECTIVE

The purpose of this module is to orient participants to the *Facts About Drug Abuse (FADA)* course, establish a climate conducive to learning, describe the training process, provide a vehicle for future exchange of knowledge and opinions, and provide a forum for identification of participants' needs, questions, expectations, and learning goals.

This module includes:

- Registration (30 minutes)
- Administering the Pretest (30 minutes)
- Structured Experience: *The Name Chain* (5 minutes)
- Structured Experience: *Likes and Expectations* (10 minutes)
- Overview: The *FADA* Course (15 minutes)

TOTAL TIME: 1 hour, 30 minutes

OBJECTIVES

Using the information presented in Module I as criteria, at the end of this module, and without the aid of notes, participants will be able to:

1. Identify the purpose of the *FADA* course.
2. Identify at least two goals of the *FADA* course.
3. Identify at least three content areas in the *FADA* course.

MATERIALS REQUIRED

- Registration forms
- Coffee and tea
- Test administration guidelines
- Pretest forms A & B
- Pretest answer sheets
- Pencils and paper for each participant
- Newsprint
- Markers
- Masking tape
- ID tags
- Large training room, with tables and chairs to seat 30 or more participants comfortably
- *The Name Chain*--structured experience instruction
- Course overview on newsprint
- *Likes and Expectations*--structured experience instructions

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
Registration Forms Coffee & Tea Name Tags Magic Markers	REGISTRATION *Registration takes place 30 minutes prior to the delivery of Module I.* • Greet participants as they arrive. • Ask each participant to sign registration form. • Check names off the list of participants. • Ask each participant to fill out and wear a name tag. • Ask participants to proceed into the large group meeting room, and help themselves to coffee or tea.
30 minutes Test Administration Guidelines Pretest Forms A & B Pretest Answer Sheets Pencils Form I-A	PRETEST ADMINISTRATION • Explain the reasons for pretest and posttest (refer to Test Administration Guidelines, found in the *FADA Trainer's Manual*, page E-4). *NOTE: The lead trainer should not administer the pretest.* • Read the pretest instructions aloud and answer questions regarding the pretest. • Ask participants to complete the pretest individually and return it to you. • Remind participants to indicate which test (A or B) they complete, and to indicate "pretest" on the upper right side of the answer form. • Distribute resource materials.
5 minutes *Name Chain Instructions*	STRUCTURED EXPERIENCE: THE *NAME CHAIN* • Explain the *Name Chain:* The purpose of the *Name Chain* is to introduce everyone. You will be asked to say your name

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
A Word About: Climate Setting	and a one-word comment about yourself after repeating the names and comments of the persons preceding you. (See full instructions in *Trainer's Manual*, page I-11.) ● Participate in the *Name Chain**.
15 minutes Course Overview	OVERVIEW: THE *FADA* COURSE ● Describe your role and that of your co-trainer(s). ● Discuss ground rules. The ground rules for this course are: - Training sessions will begin on time. - Each participant can learn from and share with others. - Differing points of view can be explored in a nonjudgmental way. - If you have questions or if something seems to be unclear, feel free to discuss these at any time. - At the end of each day, the last half hour will be devoted to sharing feedback about the day's training. ● Discuss logistics (breaks, location of restrooms, coffee, parking, etc.). ● Give a brief overview identifying: - The purpose of training - Course focus - The training schedule

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*Note: You may substitute for the *Name Chain* any icebreaker exercise that serves the purpose of introducing all of the participants. See the *Trainer's Manual*, page I-13.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- How to use the *Resource Manual.* ● Ask trainees for any questions or comments.
5 minutes	STRETCH BREAK *NOTE: You may wish to schedule a brief break now or later on.*
5 minutes *Likes and Expectations* Instructions Newsprint Markers Masking Tape	INSTRUCTIONS: A STRUCTURED EXPERIENCE, *LIKES AND EXPECTATIONS* ● Explain that this structured experience has the following goals: (1) to learn more about each other; (2) to identify each person's expectations about the *FADA* course; (3) to develop a compatible climate and readiness for interaction by sharing some personal information. ● Give the following instructions: You will be divided into small groups of four persons each. In the small groups, each participant describes two things he* likes about himself and explains reasons why. After you all have discussed your likes, describe each of your expectations about the *FADA* course and write these on newsprint for a report to the total group. The only part of this exercise we will ask you to share with the total group is the list of expectations. After we divide into small groups, each group will be given newsprint, markers, and tape. Small groups may work in the large-group meeting room or outside it--as you choose.

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*We regret that the English language does not yet have a pronoun that represents the singular for male/female. For convenience in reading, the standard male pronoun will be followed in this manual.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	You will have 20 minutes to work in the groups. At the end of that time, return to the large-group meeting room to report on your expectations. Each group should select a spokesperson to report to the total group.
20 minutes	STRUCTURED EXPERIENCE: *LIKES AND EXPECTATIONS* ● Divide participants into small groups of four persons each. (If possible, groups should be composed of people who don't know each other well.) Participants work through the exercise and list their expectations on newsprint. Participants select a spokesperson.
15 minutes	REPORT OUT: *LIKES AND EXPECTATIONS* ● Ask each spokesperson to report to the total group about his group's expectations of *FADA*. ● Ask each to check with group members to make sure that the report is accurate. ● Report on trainers' expectations about *FADA*. (Each trainer describes his own expectations.) ● Lead trainer, review with the total group what specific expectations can and cannot be met by the *FADA* course.

A WORD ABOUT: CLIMATE SETTING

In participatory training, the group atmoshpere should encourage honesty and openness. Success depends upon everyone's feeling free to participate actively, to comment, to question, to give feedback. Actively listening to others is as important as actively participating in the group. This atmosphere is often referred to as the training "climate." (For a fuller discussion of training climate, see *Trainer's Manual*, page 7.)

The training design for Module I is structured to establish a climate conducive to learning through the *Course Overview*, the *Name Chain*, and the *Likes and Expectations* structured experience.

Immediately after the pretest is concluded, the session opens with the *Name Chain*. This is a fun way of helping participants begin to become acquainted and to feel at ease with each other. It provides each participant with a low-risk experience in speaking to the entire group, and establishes an atmosphere where learning (in this case, people's names) can be an enjoyable process.

In a new situation the first need for most people is finding out what's going to happen to them. The *Overview* orients trainees to the course. The *Overview* discusses the purpose of the *FADA* ground rules, the activities of this module, the use of the *Resource Manual*, and the sequence of activities in the course. It provides trainees with information to begin to answer the questions: What is this course about? What is going to happen to me in this course?

The *Likes and Expectations* exercise is a structured way of helping participants learn more about each other. It helps participants begin to build relationships with each other--by dividing the large group into smaller groups. It facilitates involvement of people in a newly-formed group; it allows participants to become acquainted quickly in a relatively nonthreatening way. It promotes a comfortable climate for interaction within a group--through sharing personal information.

In the *Likes and Expectations* structured experience, participants identify some of their expectations about the course. You then use this information when you discuss what expectations can and cannot be met through the *FADA* course. This exercise helps participants begin to answer the questions: Who are the other people in the course? What are they like? How are we similar? How are we different?

INSTRUCTIONS

STRUCTURED EXPERIENCE: *NAME CHAIN*

PURPOSE

- To facilitate becoming acquainted--by learning each person's first name.
- To provide participants with a low-risk experience in speaking to the whole group.

TIME

5 minutes

SPACE REQUIREMENTS

One large room

SEATING ARRANGEMENT

Participants and trainers sit at a U-shaped table in one group.

MATERIALS

None

TRAINER INSTRUCTIONS

- Explain that each person will state his first name and one descriptive comment about himself. The next person will repeat the previous person's name and comment. Each person must state all previous names and comments before adding his own.
- Note the following example:

  Trainer A: Pat, hungry

  Trainee 1: Pat, hungry; Alice, tired

Trainee 2: Pat, hungry; Alice, tired; Bill, toothache

3:

4:

5:

6: etc.

Trainee 7: Joe, forgetful

Trainee 8: Joe, forgetful; Jerry, nervous

ainee 9: etc., etc.

SOME OTHER ICE-BREAKER ACTIVITIES

The activities suggested below can be helpful in at least three ways:

- as ice-breakers
- as aids for participants to begin to know each other
- as aids in identifying group members as possible future resources

Besides, these activities are fun. This list is just a beginning, and the length of your own list will grow with your experiences.

1. Paired Introduction

   Each person meets and gets to know one other person and in turn introduces his partner to the entire group.

2. Dyad and Quartet

   Same as above, but instead of introducing his partner to the entire group, he introduces him to another dyad.

3. One-Minute Autobiography

   Break into groups of a dozen or so. Each person is given one minute to tell about himself. Use a timekeeper, and don't let anyone talk longer than one minute. Restrictions can be set as to what can be talked about (for instance(s), nothing about job, family, home town, hobbies). These restrictions enable participants to focus on attitudes and values.

4. Depth Unfolding Process

   Use this activity in small groups, because it takes five minutes per person. In the first three minutes, tell what has brought you to this stage in your life. One minute is used to describe your happiest moment. The last minute is used to answer questions from others. The leader discloses first, to aid in participant comfort.

5. Structured Introductions

   In dyads, small groups, or in the large group, participants can talk about their happiest moments, write their own epitaphs, write a press release about themselves, etc.

6. Life Map

Each person draws a "picture" of his life on newsprint with crayons or magic markers, using stick figures and symbols.

7. Name Circle

Participants sit in a large circle. The leader begins by stating the name of the person seated to his right, followed by his own name. The person to his right repeats the leader's name, his own name, and adds the name of the person seated to his right. This process is repeated around the entire circle.

8. Sandwich Boards

Each person writes on a sheet of newsprint "Things I Know" (about the content and purposes of the course, areas of personal expertise, etc.). On a second sheet of newsprint, he write "Things I Want to Know." The sheets are joined with tape, sandwich board style, and the participants mill around, non-verbally, identifying resources and getting to know one another.

9. Consensus-Based Group Objectives

Each person privately lists five (the number is optional) personal objectives for the course. He shares them with a partner, and they arrive at five mutual objectives. The dyads go to quartets, then to octets. The octets report out their objectives (reached by consensus) and a total-group set of objectives is formed. This activity can aid in checking the contract, and can help obviate the problem of hidden agendas.

10. Sentence Completions

A prepared list of sentences ("Anyone who smokes in front of his children" . . .) is spun around the group or used in small groups.

COURSE OVERVIEW

PURPOSE

Course goals are:

- To identify inaccurate images and unsound assumptions about substances, abuse, and use that can impede progress in dealing with substance abuse.
- To examine the phenomenon of drug addiction.
- To consider the social and historical development of substance use in this country.
- To provide an accurate description of those psychoactive drugs abused often, and to place their relative hazards in perspective.
- To identify methods of drug abuse treatment.
- To explore the role of family, school, community, and peer groups in drug abuse prevention efforts.

OBJECTIVES

Using the information presented in the *Facts About Drug Abuse* course, at the end of this course, and without the aid of notes, the participants will be able to:

- Identify at least three elements basic to use of any drug.
- Identify at least four different perspectives for perceiving drug use.
- Identify the scientific definition of a "drug."
- Identify at least three levels of dosage for every drug discussed.
- Identify at least four stages in the history of the use of drugs that lead to dependence.
- Identify at least three main features of addiction.
- Identify at least four generating factors indicating the causes and conditions related to the drug-taking process.

- Identify at least three of the "vicious cycles" related to drug addiction.

- Identify at least three factors leading to development of a dependent substance-user patter that are related to the painkilling function of substances (drugs).
- Identify at least three factors leading to development of dependent substance-user patterns that are related to the social-recreational functions of substances (drugs).
- Identify at least three major events that led to the "intensifying" use of substances during 1960's.
- Identify one social and one legal response to substance abuse post-Civil War.
- Identify one social and one legal response to the use of alcohol.
- Identify at least three changes, since 1965, in social and legal responses to substance abuse.
- Identify at least four perspectives drawn from history that represent consequences of the drug laws on certain groups.
- Identify the difference of withdrawal syndrome related to heroin and alcohol.
- Identify at least three commonalities related to heroin and alcohol.
- Identify at least three reactions to consumption of sedative hypnotics (particularly alcohol) that can lead to convulsions.
- Identify at least three reactions to consumption of sedative hypnotics (particularly alcohol) that can lead to coma.
- Identify at least one advantage and one disadvantage of each of these treatment methods:

    - methadone maintenance
    - therapeutic communities
    - extended group psychotherapy.
- Identify at least four major strategies of prevention that correspond to drug-individual-context variables.
- Identify at least three principles that can determine the effectiveness of information and communications related to drug abuse prevention.
- Identify at least one key to the effectiveness of the alternatives approach as a deterrent to drug use.

- Identify at least four roles a family can play as a deterrent to drug use.
- Identify at least one role a school can play as a deterrent to drug use.
- Identify at least one role a peer group can play as a deterrent to drug use.
- Identify at least two directions the Federal Government is taking to prevent the use of drugs.

AUDIENCE

This course is designed to train drug abuse prevention and treatment workers (or their direct supervisors), teachers, guidance counselors, drug educators, school psychologists, PTA/PTD members, recreation workers, youth workers, peer counselors, gang workers, youth employment counselors, parole and probation officers, outreach workers, hot-line workers, people working with youth overseas,military personnel, and community service organizations.

CONTENT

Module I: Introduction & Orientation
Module II: The "Problem" with "Drugs" and "Drug Abuse."
Module III: The "Problem" with "Drug Addiction"
Module IV: A Social and Historical Context for Understanding Substance Use in the United States
Module V: Substance Actions and Potential Hazards
Module VI: Understanding and Overcoming Substance Dependence
Module VII: Prevention and the Community, School, Family, Peers and Youth
Module VIII: Roles and Strategies For Prevention
Module IX: Closure and Evaluation

METHODOLOGY

Lectures, mediated demonstrations, guided group discussions, task group exercises, and individual reading assignments.

TIME REQUIREMENTS

Total training time is 28 hours, plus six hours of individual reading assignments.

STRUCTURED EXPERIENCE: *LIKES AND EXPECTATIONS*

GOALS

- To give participants an opportunity to learn more about each other.
- To develop a compatible climate and readiness for interaction in a group by sharing personal information.
- To identify each person's expectations about the *FADA* course.

TIME

40 minutes

SPACE REQUIREMENTS

One large room or one large room and several small-group rooms.

MATERIALS

- Newsprint
- Markers
- Masking Tape

TRAINER INSTRUCTIONS

- State the goal of the structured experience.
- Explain that participants will be divided into groups of four persons each, and will describe two things each person likes about himself, and why he feels this way (15 minutes). Then each participant will identify his expectations about the *FADA* course and list those on newsprint (5 minutes).
- Divide participants into groups of four persons each to carry out the exercise. Small groups should choose a spokesperson for their report to the total group.

- Circulate to each small group to obtain the flavor of group discussion and to remind participants about time.
- Ask the spokepersons for small groups to report to the total group on participants' expectations. (If each person in the small group would like to describe his own expectations to the total group, that's helpful in clarifying expectations.) Then each trainer should share his expectations with the total group. The lead trainer will review all the expectations listed and identify those that can and can't be met in this course (15 minutes).

MODULE II

THE "PROBLEM" WITH "DRUGS" AND "DRUG ABUSE"

MODULE II: THE "PROBLEM" WITH "DRUGS" AND "DRUG ABUSE"

PERSPECTIVE

The purpose of this module is to provide information on and give participants new ways to consider the phenomenon of drug abuse. The module begins with an exercise that will help the group consider some of the inaccurate images and unsound assumptions about substances, abuse, and use that can impede progress in dealing with problems associated with substance abuse.

This module includes:

- Overview of Module II (10 minutes)
- Structured Experience: *The Dependency Checklist* (35 minutes)
- Lecture/Discussion: The "Problem" with "Drug Abuse" (10 minutes)
- Lecture/Discussion: Perspectives (40 minutes)
- Total Group Exercise: *Definitions and Perceptions* (10 minutes)
- Lecture/Discussion: Drugs (10 minutes)
- Lecture/Discussion: Drug Effects (10 minutes)
- Lecture/Discussion: Feelings, Moods and Perceptions (15 minutes)
- Lecture/Discussion: Tolerance and Dependence (10 minutes)
- Lecture/Discussion: Doses (10 minutes)
- Lecture/Discussion: Unknown Substances (10 minutes)
- Summary of Module II (5 minutes)

TOTAL TIME: 3 hours

OBJECTIVES

Using the information presented in Module II as criteria, at the end of this module, and without the aid of notes, participants will be able to:

1. Identify at least three elements basic to the use of any drug.
2. Identify at least four different perspectives for perceiving drug use.
3. Identify the scientific definition of a "drug".
4. Identify at least three levels of dosage for every drug discussed.

MATERIALS REQUIRED

- *The Dependency Checklist*
- *Drugs Demystified* by Helen Nowlis; Chapters 1 and 2
- Markers, tape, newsprint
- "Perspectives" written on newsprint
- "Feelings, Moods, Perceptions" written on newsprint
- "Pharmacological Effects" written on newsprint
- "Tolerance, Physical, and Psychological Dependence" written on newsprint
- "Doses" written on newsprint
- "Drug", "Drug Abuse", and "Addict" written on newsprint
- Small and large group meeting space

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	OVERVIEW: MODULE II ● Review the objectives of Module II with the total group. ● Explain the sequential flow of the module, highlighting: - Large group introduction to the content - Small group activities - Lecture presentation by the trainer - Large group discussion ● Introduce the module as follows: In this module we'll be concentrating on finding new ways to consider the phenomenon of drug abuse. It is hoped that this effort will allow us to examine some of the inaccurate images and unsound assumptions about substance abuse and use that can impede progress in dealing with problems associated with substance abuse and dependent behavior. Let us define dependent behavior as: *any behavior a person does that, if stopped, would produce discomfort.* Let us define discomfort in the very broadest terms, as ranging from a sense of uneasiness to actual, objective, physical symptoms. As a sample of minimum discomfort, let us consider such habits as reading the comics or watching a morning news program, and then not being able to get the paper or watch TV. For most of us, maximum discomfort might be experienced by giving up cigarettes, coffee, or the daily cocktail. As a prelude to the small group exercise, let us take a few minutes to consider our own dependencies.
5 minutes	● Ask each participant to tell the group what his minimum and maximum discomfort dependencies are.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	Explain the small group activities: - When you break into small groups you will be working with *The Dependency Checklist* in your *Resource Manual*, page II-31. You will be doing two things. The first will be to order some "dependencies" according to various possible reasons for their existence. You need not respond to every item on the dependency checklist, and you are free to assign as many different reasons to each one as you feel is appropriate. Also, feel free to add your own items to each side of the list. The second purpose of the activity is to have you look at the history of your own "dependency" to see if it exists because of original external influence (e.g., attending religious services). ● Divide the large group into three small groups.
20 minutes	SMALL GROUP DISCUSSION ● Ask the small groups to complete *The Dependency Checklist* in five minutes. ● Discuss the activities that were listed by participants. ● Allow about 20 minutes for this discussion, but try to give each participant an opportunity to speak if they want to. ● Return to the large group for the lecture presentation.
5 minutes	LECTURE: THE "PROBLEM" WITH "DRUG ABUSE" *NOTE: The following information should be presented to the large group. While salient points from Nowlis are abstracted here, it is essential that the trainer be thoroughly familiar with the Nowlis readings. Although participants might have to read this material, it must not be assumed that they have digested it fully.*

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	● State the following: In the exercise just completed, we have looked at some fairly harmless behaviors with the intention of trying to understand how and why they became part of our lives. It is important to learn to look at drug use with a similar perspective. - Societies and nations around the world have defined the use of certain substances by certain people for certain reasons as a problem. The substances, the people, the circumstances vary from place to place, from culture to culture. In many instances, the perceived characteristics of particular groups of people using drugs and their supposed reasons for using them determine the nature and extent of the response to use more than the particular substance used. In some instances, the emergence of the problem represents a new view of a familiar practice. - For example, use of marihuana by Jamaican farm laborers as part of their working day, or the long-standing occasional use of amphetamines by students in order to stay awake to study for an examination or to finish a term paper. In other cases, the problem status of a particular kind of drug use is a function of the emergence of use in new segments of the population, notably among youth (in contrast to adults) and in groups other than lower class and minority groups. In still other cases, as a result of instant communication among the nations of the world, the problem is merely the fear that use of certain substances by certain groups will occur at home as it has elsewhere. Whatever the case, a problem is perceived and a solution is sought. Many initial responses are hasty, often emotional or irrational, and seldom either wise or productive.

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	- Effective problem solving requires careful definition of the problem (in descriptive rather than emotional terms), evaluation and selection of methods, tools, and strategies relevant to the problem as stated, and constant evaluation of progress, identification of errors, and willingness to try new approaches when old ones fail. Drug problems have been so ill-defined, in such global and value-laden terms, that it is little wonder that disagreement and controversy prevail. The problem must be defined in objective, descriptive terms: Who is using what substance with what frequency for what reasons. - There are three basic elements in the use of any drug, licit or illicit, medical or non-medical: (a) the substance; (b) the individual who uses it; and (c) the social and cultural context in which drug use occurs. Any approach to remedy the problem must take account of all three factors. Action based exclusively on any one will probably fail. Each element is complex; the relative degree of complexity with which each is perceived usually depends on the experience, background, training, and personal or professional investment of the viewer. 1. To the pharmacologist, each drug--its mode of action, and its effects--is complex. Complexities regarding the individual or the context, if recognized, are factors to be controlled rather than emphasized to explain variations. On the other hand, most of the general public including those who make judgments, legislative or otherwise, about drugs, drug effects, and people who use drugs, tend to have a simplistic view of drugs. - The majority believes that all drugs can be divided into two mutually exclusive

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	categories: *good and safe or bad and dangerous.* There is a tendency to consider drugs so categorized as similar, if not equivalent, and users of such drugs as all alike. Drugs labeled as dangerous, and whose use has been declared illicit are grouped together under a label such as "narcotic," and distinctions among them tend to be minimized. 2. To the psychologist or behavioral scientist, the individual is extremely complex and variable. No explanation or action can hope to be effective unless such complexity and variability are recognized. Drug use is viewed as simply one instance of human behavior, and as sharing the characteristics of all human behavior. The complexities of drugs are but one term in the human equation. 3. To the social scientist, variations in the social and cultural context of drug use are the complex factor. Cultures and subcultures define and respond to drug use in different ways. They approve or disapprove the use of certain substances. They state who may or may not use a given substance and under what conditions. Reasons for drug use are sought in such factors as institutional failure, social and economic conditions, and societal responses to problems associated with drug use.
5 minutes	• Ask group members if they have any questions about what was presented thus far. If so, respond accordingly. • Write the following on newsprint PERSPECTIVES (1) Moral-Legal Perspective (2) Disease or Public Health Perspective

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	(3) Psycho-Social Perspective (4) Socio-Cultural Perspective
5 minutes	LECTURE: PERSPECTIVES ● State the following: - There are four major points of view with regard to drug use and its three interacting components (substance, user, context): the traditional moral-legal, the medical or public health, the psycho-social, and the socio-cultural. Each varies in its assumptions about drugs, about people, about social and cultural context, in terms of the nature and relative importance of each. At the risk of gross oversimplification, and recognizing that there are many variations in each, these views can be described as examples of the diversity of assumptions made about drugs, about people, and about societies. - *Each of these sets of assumptions has implications for social action, education, prevention, treatment, legislation, and policy formulation.*
5 minutes	LECTURE: THE MORAL-LEGAL PERSPECTIVE: ● State the following: ● - The traditional moral-legal perspective has placed major importance on the drug. Drugs are classified as "safe" or "dangerous," where safe means *not designated as dangerous* or *not socially or legally prescribed*. The primary goal is to keep specific drugs away from people. Drugs are assumed to be the

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	active agent, people to be the uninformed, unwilling, or deviant victims who must be protected via legal controls on cultivation, processing, manufacture, distribution, sale, sharing, or possession of the substance--even, in some instances, on possession of the paraphernalia or instruments for using the specific drugs. - The principal deterrents are considered to be: control of availability of drugs; increase in cost of drugs; punishment or threat of punishment; and warnings of great physical, psychological, and social harm. Great emphasis is placed on the dangerous effects of drugs in an effort to deter use. - Educational programs based on these assumptions often stress information about the dangers of those specific drugs, about their legal status, and the penalties attached to sale, use, and possession. Just as drugs are dichotomized as licit or illicit, individuals tend to be dichotomized as users and non-users--without regard to the kind of drug used or pattern of use. Although distinctions are sometimes made between "soft" drugs and "hard" drugs, both drugs and individuals tend to be dichotomized on the basis of legal or illegal, medical or non-medical.
5 minutes	LECTURE: THE DISEASE OR PUBLIC HEALTH PERSPECTIVE ● State the following: - In the public-health perspective, which has been increasingly considered as an alternative to the moral-legal perspective, "drug, individual, and context" are translated into "agent, host, and context," following the infectious disease perspective. Although differ-

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ences between these two perspectives may seem subtle, they have an important influence on the nature of control, treatment, or prevention action recommended. In this perspective the drug as agent assumes, as in the moral-legal perspective, the major role in the triad.

- The drugs causing concern are defined as dependence-producing (rather than simply dangerous as in the moral-legal perspective), but the two perspectives share a major emphasis on drug or substance as the active agent. A major difference between the two perspectives is that *the public health view does not distinguish between licit and illicit*. Therefore, it often includes alcohol, nicotine, and caffeine as dependence-producing; but distinguishes them from other dependence-producing drugs on the basis of the contextual (social) variables of social acceptability and widespread availability and use. Decrease in social acceptability and increase in cost of dependence-producing substances thus become a means for possible reduction in use as well as control of availability.

- The individual or host is viewed as vulnerable or not vulnerable, as infected and infectious. Since the identification of vulnerable individuals is far from perfect, there are various attempts to "vaccinate" by measures that include prevention-oriented educational programs that tend to rely on information about the risks involved in initiating use of designated substances, and the personal and social harm caused by becoming dependent on those substances.

- Although those adherents to the public-health perspectives who are most experienced in dealing with drug use and drug users recognize inadequacies and seem to be moving toward accepting a psychosocial perspective, the public

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	health perspective still represents their basic concept of the nature and relative importance of drug, of individual, and of context. It determines to a major extent the manner in which they respond to problems associated with drug use: *Drug users are to be treated and cured as a medical problem.* Drug use is to be prevented as a public-health problem, just like any infectious disease.
5 minutes	LECTURE: THE PSYCHO-SOCIAL PERSPECTIVE ● State the following: - The psycho-social perspective tends to put major emphasis on the individual as the active agent in the drug-individual-context formulation. Drug use and drug user (rather than pharmacological substances) are emphasized. They are the focus of intervention efforts. This perspective is concerned with the meaning and function of drug use to the individual, with drug use as behavior that, like other behavior, would not persist unless it served some function for the individual. It tends to make distinctions among: different amounts, frequencies, and patterns of drug use; the different functions that drug use may serve; the differential effects of different patterns of drug use in different people. - It is concerned with context in terms of the influence of the perceived attitudes and behavior of other people--individually or in social groups such as families, peer groups, and communities. Context is seen as a contributor both to use and the problems associated with use--via interpersonal definition of, and response to, drug use and drug users. - Because of its emphasis on individuals and their behavior, and on the role of social factors, this model often recommends non-drug-specific responses to drug use that turn out to be equally applicable to other destructive or deviant behaviors.

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5 minutes	LECTURE: THE SOCIO-CULTURAL PERSPECTIVE

- State the following:
  - Those who view drug use and the problem associated with drug use from the socio-cultural point of view tend to emphasize and recognize complexity and variation in the drug-individual-context triad. Specific drugs gain their meaning and significance not so much from their pharmacological properties, but from the way in which a given society defines and responds to their use and their users. Socially-proscribed drug use is seen primarily as deviant behavior to be viewed and treated along with other deviant or, if excessive, destructive behaviors.
  - As in all deviant behaviors, harm may come to the individual either from the behavior itself or from society's response to that behavior. This point of view recognizes that such behavior will of necessity vary from culture to culture, from subculture to subculture.
  - It stresses socio-economic and environmental conditions as the reasons for psychological stress and, therefore, as the basic focus of intervention. Poverty, poor housing, discrimination, lack of opportunity, industrialization, urbanization are seen as the breeding ground of the more personal factors that the psycho-social model emphasizes--factors such as broken homes, lack of parental guidance, impersonal educational and work institutions, and breakdown in social controls.
  - This view also recognizes that, despite the tendency to see undesirable behavior always as the result of undesirable aspects of the social system, much that is disapproved of is linked initially with things that are approved of and

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	valued.
5 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.
10 minutes	● Summarize, stating the following: - Each of these perspectives represents a vantage point from which to view drug use and the phenomena associated with it. Each leads to different recommendations and actions designed to modify drug use. Each represents a lens through which to view: drug, human, society, and the interactions among them: the kinds of behaviors emphasized within each context; the nature of the response; and the relative ability of various institutions and professions to intervene most effectively. - If the challenge is to keep drugs away from humans, laws and law enforcement will be given a major role. If it is to keep humans away from drugs, the responsibility will be that of those skilled in the behavioral sciences. If it is to create an environment in which the needs drug use serves are served better by behavior involving less risk, less potential for harm to the individual and the society, every institution (and the individuals who have roles in each institution) has a role to play . - Four important new trends are developing in the definition of, and response to, socially-disapproved and destructive drug use. These have occurred primarily in those countries and parts of countries that have struggled longest to modify unacceptable drug use. They have occurred only after other approaches have been tried.

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	- The first of these new trends is defining the problem in psycho-social terms (rather than pharmacological, legal or medical terms), placing increasing emphasis on drug use as a behavior. - The second is adopting as a primary goal not the prevention of drug use, but the reduction of the problems associated with *destructive* drug use. - The third is an increasing, though not dramatic, willingness to put socially-disapproved drug use by youth into the context of use of all drugs, licit and illicit, by people of all ages. - The fourth, closely associated with the third, is a willingness to include alcohol as a drug, and to consider the implications of its use by both adults and youth. - Indications of these trends are abundant in the conclusions and recommendations of a number of recent international meetings. That these meetings have included among their participants and consultants an increasing number of social and behavioral scientists, of individuals working directly with young drug users, and of youth themselves, is perhaps both a recognition of these trends on the part of the conveners and the major factor influencing the recommendations that resulted. At the very least tney suggest a willingness to entertain the possibility that traditional responses by traditional institutions have been less than effective. - Each of these trends has important implications for both parents and teachers in their roles as educators, for both families and schools in their roles as the institutions charged traditionally with socialization of the young. They define the goals of any attempt to influence drug use and, in turn, the choice of methods

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	and strategies for reaching those goals. - It could be concluded that with as many perspectives as we have on drug abuse, there is undoubtedly confusion about what the terms "drug," "drug abuse," "addict," actually mean.
10 minutes	TOTAL GROUP EXERCISE: *Definitions and Perceptions* ● Tell the group that the following exercise will aid in illustrating the "definition" and "perception" problems relating to the "drug abuse" and "drug addict" problems. Remind the group that the way problems are defined and perceived is as much a problem as the problem itself. ● Tape three sheets of newsprint to the front wall. At the top of the first sheet write the word "DRUG"; at the top of the second sheet write the word "DRUG ABUSE"; at the top of the third sheet write the word "ADDICT." ● Ask participants to define the term "DRUG." Record their responses on newsprint. ● Ask participants to define the term "DRUG ABUSE." Record their responses on newsprint. ● Ask participants to describe, with one word, their perception of an addict. Record their responses on newsprint. ● State the following at the conclusion of this exercise: - Discussions of drugs and drug effects abound in ill-defined terms, imprecise concepts, and over-generalizations. Even when the same words are used and the illusion of communication exists, non-communication and controversy are often the reality. Necessary discriminations are not made, assumptions are not examined, stereotypes are invoked con-

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	sciously or unconsciously, fact is not distinguised from opinion and feeling. - One and the same substance may be referred to as *psychoactive*, *psychotomimetic*, *psychodysleptic*, *psychedelic*, *dangerous*, *dependence-producing*, *hallucinogenic*, even *narcotic* all with little regard for its basic pharmacological actions. - Each term carries with it a halo of feeling, belief, expectation, and judgment that goes beyond the specifics of pharmacological action. Each term attributes to the substance itself characteristics that more properly belong to the interaction among substance, organism and context. - Because of the confusion resulting from such lack of precision, and in an effort to communicate more effectively, traditional labels will be avoided and more descriptive phrases will be used for the rest of this session. This is done for two major reasons: (a) to separate scientific fact, which is the same across cultures and national boundaries, from value judgment, which is highly culture-relevant and often culture-specific; and (b) to try to establish a common ground for discussion across cultures and across languages. - Such definitions will themselves be controversial for, in areas where belief, values, and feeling are strong, neutral terms seem almost a denial of those beliefs. Values, beliefs, and feelings are important. Without them, life would be empty and meaningless, but they must be considered separate from drugs as pharmacological agents and from the actions of drugs.
5 minutes	LECTURE: DRUGS

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- State the following:

  - The basic pharmacological or scientific definition of a drug is "a substance that by its chemical nature, affects the structure or function of the living organism." The mode of action and the nature of the effects of drugs is the subject of pharmacology.

    It will take only a moment's thought to realize that this definition covers virtually everything that people ingest, inhale, inject, absorb. It includes medicines, over-the-counter drugs, illegal drugs, drugs that are commonly referred to as beverages or cigarettes, food additives and preservatives, many industrial chemicals, pollutants, even food itself. An immediate reaction is certain to be that this is not a very useful definition. It is certainly not the way most people think of and respond to the term "drug." From many points of view, it is so general as to be of little use, but it highlights the important fact that something more than pharmacology is necessarily involved in most current definitions of drugs.

  - These definitions have more to do with the purposes for which substances are used than with any characteristic of the substance itself or the way in which it interacts with the living organism. These purposes vary from time to time and from place to place. Alcohol as a substance is a drug. Under the name ethyl alcohol, it appears in most pharmacological and medical texts. To label it a beverage in no way changes the way in which it interacts with the organism. It is still a central nervous system depressant.

  - From a pharmacological point of view, a drug is a drug regardless of how or why

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	it is used or what it is called. And all drugs interact with the living organism according to the same well-established principles. These are not the kinds of principles that most people assume. These principles involve effects that are probably and variable rather than certain and invariable.
5 minutes	Ask participants if they have questions about the definition. If so, respond accordingly.
5 minutes	LECTURE: DRUG EFFECTS State the following: - According to the Second Marihuana Commission: "The term [drug abuse] has no functional utility and has become no more than an arbitrary codeword for that drug use which is presently considered wrong." - For purposes of understanding the problem of definition and perspectives when speaking of drug abuse, one should have a working knowledge of drug effects. - There is no such thing as the single effect of any drug. All drugs have multiple effects and these vary. - Effects vary from dose level to dose level, from individual to individual, from time to time, and from setting to setting in the same individual. Drug effects are a function of the interaction between the drug and the individual defined physiologically, psychologically, and socially. Individuals are complex and varied. Drug effects must therefore be complex and varied. For every drug there is (a) an effective dose, (b) a toxic dose, and (c) a lethal dose. Each of these dose levels is a

statistical abstraction, an average.

- Each is the dose by which 50 percent of a given group show (a) whatever effect is sought, (b) whatever effect is defined as toxic (either physically or behaviorally), or (c) die.
- At low and moderate dose levels it is a scientifically-demonstrated fact that non-drug factors (such as the physiological and psychological characteristics of the individual, his current physiological and psychological state, the reasons why he takes the drug, what he expects the effects will be, the physical and social setting in which he takes it) are often more important in determining the effects of a given drug than any characteristic of the drug itself.
- One has only to think about the effects of alcohol which may make the drinker sociable, talkative, withdrawn, depressed, gay, tearful, sleepy, abusive, destructive uninhibited, drunk or comatose. It all depends on who, why, where and how much.
- Individuals vary in weight, age, sex, sickness, and health. They vary in the ways they react to their perception of physiological and psychological changes in themselves, and of changes in their physical and social environment. The meaning and significance of these perceptions for personal and social adjustment varies. All are influential in determining the response to any drug.
- *All drugs, even food and water, are dangerous for some individuals at some dosage level under some circumstances.* Some are more dangerous at lower dosage levels for more individuals than are others. Use of any drug involves risks.
- But most of what people do, if they do anything, involves some degree of risk

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	and is done because of some perceived benefit. - Who takes what risks for what benefits is a basic problem both for individuals and for societies. ● Write the following terms on newsprint: "Feelings" "Moods" "Perceptions"
5 minutes	LECTURE: FEELINGS, MOODS, AND PERCEPTIONS ● State the following: - Most current concern is with substances whose primary effects are on the central nervous system. An important pharmacological characteristic of such substances is that they facilitate changes in feeling, mood, or perception. People have always sought to change feeling, mood, perception, and orientation to self and environment. They probably always will. The use of psychoactive substances is only one of the many ways in which they seek to accomplish this, but it is one that has persisted throughout the ages and throughout the world. ● Write the following on newsprint: PHARMACOLOGICAL EFFECTS 1. Relief of pain. 2. Reduction of uncomfortable or unwanted levels of activity or feelings. 3. Increase in level of activity and feelings of energy and power, reduction in feelings of fatigue, depression, sleepiness.

4. Changes in habitual ways of perceiving and orienting one's self toward one's physical and social environment.
5. Various levels of intoxication.

- State the following:
  - From the perspective of behavior, there are five major pharmacological effects sought from psychoactive substances. All involve changes in feeling, mood, or perception. Most frequently these changes include:

1. Relief of pain. Opiates are still the preferred substance.
2. Reduction of uncomfortable or unwanted levels of activity or feeling such an anxiety, nervousness, jitteriness, sleeplessness, too much stimulation, unwanted or unmanageable levels of basic drives such as sex or aggression. Any central nervous system depressant can serve this function for most people. Alcohol barbiturates, and opiates are major depressants.
3. Increase in level of activity and feelings of energy and power; reduction in feelings of fatigue, depression, sleepiness. Any central nervous system stimulant such as caffeine, amphetamines, cocaine, or a variety of synthetic substances are used widely for these purposes. It is of interest to note that the majority of prescriptions written by physicians are for these three purposes.
4. Changes in habitual ways of perceiving and orienting one's self toward one's physical and social environment--exploring, getting outside of one's self, gaining new insights, increasing creativity, and increasing the intensity and enjoyment of sensory and esthetic experiences. Whether any of these effects can be documented objectively or not, or is actually an effect of the substance as claimed, they all motivate or reinforce drug use.
5. Various levels of intoxication--the lightheadedness, exhilaration, feeling of floating or dizziness that may come from such diverse

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	activities as twirling until balance is almost lost, fasting, breathing deeply and rapidly, or taking any of a variety of substances. Alcohol, barbiturates, cannabis, inhalants, and solvents are the most widely used substances.
5 minutes	● Ask group members if they have questions. If so, respond accordingly.
	Write the following terms on newsprint: 1. Tolerance 2. Physiological or Physical Dependence 3. Psychological Dependence
5 minutes	● State the following: - There are also effects that depend both on special pharmacological characteristics of some drugs and on patterns of use of those substances. In general, these effects are not substance-specific. They combine pharmacological characteristics with patterns of use over time. The phenomena are *tolerance* and *physiological or physical dependence*. - A third phenomenon, *psychological dependence*, will be considered later because, while not unrelated to physiological dependence, it is much more complicated pharmacologically, psychologically and socially. - Because of the way that some substances interact with the organism at a biochemical level, after repeated and frequent use a progressively higher dose is required to produce the same effects produced originally by a smaller dose. This phenomenon is known as *tolerance*. The importance of tolerance is that it results, up to a point that varies from

drug to drug, in progressive increases in dose level necessary to obtain the desired effect, and in increasing risks due to resultant high dose levels.

- A second phenomenon that depends on special characteristics of some drugs as pharmacological substances in conjunction with patterns of use of these substances is *physiological dependence.*
- Certain substances, notably opiates and their derivatives, barbiturates, alcohol, amphetamines, caffeine, and nicotine, when used in sufficient amounts and frequencies over a period of time, produce changes in the organism so that it is not able to function "normally" without the drug. The amount, frequency, and period of time required vary from substance to substance. There is now some evidence that suggests physiological dependence on some substances at sufficiently high dosage levels over a long enough period of time may result in such lasting or even permanent changes in the organism that it will require the presence of the substance or some suitable substitute on an indefinite basis.
- *From a strictly pharmacological point of view, drugs, defined broadly, are substances which the organism metabolizes, eliminates, or, if it can do neither, either adjust to their continued presence and thus require them, or be damaged or destroyed by them.*
- In contrast to a disease (with which it is often compared) physiological dependence occurs on a curve of increasing use of specific substances, preceded by a long series of actions on the part of the individual. He must have decided to try the drug, must value its effects enough to continue to use it over a period of time, usually in increasing amounts and with increasing

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	frequency. This value represents the important psychological component of physiological or physical dependency.
5 minutes	● Ask group members if they have questions. If so, respond accordingly.
	● Write the following terms on newsprint: DOSES 1. Legal versus illegal 2. Effective dose 3. Toxic dose 4. Lethal dose
5 minutes	LECTURE: DOSES ● State the following: - The effects of drugs used legally and for medical reasons are a function of dose. For each drug there is an effective dose, a toxic dose and, for most, a lethal dose. The effects of drugs used illegally or for non-medical reasons are a function of dose. For each there is an effective dose, a toxic dose, and for most, a lethal dose. - All drugs have multiple effects or side effects beyond those for which they were taken or prescribed. The side effects of drugs used legally are often critically important and may include such common effects as drowsiness, distractability, irritability, temporary lapse of memory and, more rarely, hallucinations, intoxication, hyperexcitability, and similar phenomena. - The effects of moderate-dose levels are highly dependent on non-drug factors. At high-dose levels, and for some people

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	at much lower levels, all drugs may be dangerous. Some licit drugs have been demonstrated to produce a statistically-significant (i.e. greater than chance) increase in the occurrence of chromosome breakage in white blood cells. Some illicit drugs have been demonstrated to produce a statistically-significant increase in the occurrence of chromosome breakage in white blood cells. - Some licit drugs, when taken during certain critical periods of pregnancy, produce a statistically-significant increase in the occurrence of fetal deformities. Some illicit drugs,when taken during certain critical periods of pregnancy, produce a statistically-significant increase in the occurrence of fetal deformities. Certain drugs used legally may produce physiological dependence. The same drugs used illegally may produce physiological dependence.
5 minutes	● Ask group members if they have questions. If so, respond accordingly.
	● Write the following on newsprint: UNKNOWN SUBSTANCES
5 minutes	LECTURE: UNKNOWN SUBSTANCES ● State the following: - It has become a practice when writing on drug use to catalogue the increasing number of substances used illegally or for non-medical purposes, listing in detail the official name of the drug, its street names, the usual single dose, the duration of action, the method of taking, its effects, the effects of toxic doses implied to be the usual effects, its potential for tolerance,

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	for physiological dependence, and for psychological dependence. - There is a certain irony in these charts, even if they are both accurate and objective. Most of the substances available outside normal licit channels are often not the substance they are purported to be, or are contaminated with other substances, and there is seldom accurate information as to the dosage level involved. - Reports from laboratories set up for the analysis of street drugs in Canada, the United States, and various European countries attest to this. The imagination and ingenuity, even malevolence, of the purveyors of these illegal products are apparently endless. At one time when mescaline was widely reported to be the drug of choice for certain groups, analysis of samples sold as mescaline indicated that many contained no mescaline at all, indeed were predominantly lysergic acid diethylamide (otherwise known as LSD), often with strychnine added. - Workers in crisis clinics and emergency hospital wards who are thoroughly familiar with the drug scene and who take their mission seriously, feel compelled on an almost weekly basis (or on reports of regular informants) to analyze the drugs on the street at any given time so that they can repond better to emergencies. Lacking such information, they feel constrained to limit themselves to treating observed symptoms. - Taking an unknown substance in an unknown amount (alone or in combination with another substance) increases the normal risks involved in drug use immeasurably, especially when the individual has little knowledge or understanding of drug action. These risks arise more from factors in the context, such as the fact that the drugs are

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	available only on the black market and are of unknown composition, purity, and dose, then they do from characteristics of the particular substance involved.
5 minutes	● Ask group members if they have questions. If so, respond accordingly.
	SUMMARY
5 minutes	● Summarize by stating the following: - When one considers the use of the term "*drug abuse*" one should keep in mind the definition of the word *drug*. Also one should keep in mind the terms *effective dose, toxic dose, lethal dose, feelings, moods, perceptions, pharmacological effects, tolerance, legal versus illegal dose, physical dependence, and psychological dependence.* - It is no wonder that the Second Marihuana Commission has stated, "The term [drug abuse] has no functional utility and has become no more than an arbitrary codeword for that drug use which is presently considered wrong." END OF MODULE

THE "DEPENDENCY" CHECKLIST

INSTRUCTIONS

For each act that applies to you, put the number of as many reasons as seem appropriate next to the act. Try to remember your initial reasons (and include these) for doing the act, as well as your current reason(s). Even if some acts don't apply, you may fill in reasons if you can imagine yourself doing the act.

Feel free to add items to either side of the list.

When you have completed the checklist, circle three or four items that have at least six reasons assigned to them. These acts will be the ones you will use for examining their historical development in your life.

THE "DEPENDENCY" CHECKLIST

Acts

Smoking
Drinking coffee/tea
Having a drink
Watching a particular TV show
Playing a musical instrument
Making love
Eating pastry on Sunday morning
Walking the dog
Going to religious services
Playing a sport
Sunbathing
Cooking dinner
Being a parent
Not being a parent
Having an after-dinner liqueur
Taking a tranquilizer
Taking vitamins
Buying a house
Having a savings account
Paying each bill the day it comes in
Not being late
Buying clothes
Grocery shopping
Reading a book
Having a routine
Having a place for everything

Reason

1. Makes me feel good.
2. Reduces tension.
3. Puts order in my life.
4. Gives me something that is uniquely mine.
5. Perks me up.
6. Calms me down.
7. Provides a change of pace.
8. Gives me social acceptance.
9. Gives me a sense of well-being.
10. Makes me anxious if I don't do it.
11. Makes me feel guilty if I don't do it.
12. Makes me feel "square" if I don't do it.
13. Makes me feel in control of my life.
14. Usually I just have to do it--it is one of life's givens.

REFERENCES

Nowlis, Helen. *Drugs Demystified*. Paris: The Unesco Press, 1975. Chapters 1 and 2.

MODULE III

THE "PROBLEM" WITH "DRUG ADDICTION"

MODULE III: THE "PROBLEM" WITH "DRUG ADDICTION"

PERSPECTIVE

The purpose of this module is to provide information on and give participants new ways to consider the phenomenon of drug addiction. This module begins with an exercise that will assist the group to look at some of the unclear images and unsound assumptions about addicts and addiction that can impede progress in dealing with problems associated with addiction as a dependent behavior.

This module includes:

- Overview of Module III (10 minutes)
- Lecture/Discussion: Stages of Dependence (10 minutes)
- Lecture/Discussion: Shifting From Use to Addiction (15 minutes)
- Lecture/Discussion: Generating Factors (15 minutes)
- Lecture/Discussion: Vicious Circle (30 minutes)
- Small Group Exercise: *Definitions and Perceptions* (60 minutes)
- Summary of Module III (30 minutes)

TOTAL TIME: 3 hours, 15 minutes

OBJECTIVES

Using the information presented in Module III as criteria, at the end of the module, and without the aid of notes, participants will be able to:

1. Identify at least four stages in the history of the use of drugs that lead to dependence.
2. Identify at least three major features of addiction.
3. Identify at least four generating factors indicating the causes and conditions related to the drug-taking process.
4. Identify at least three of Van Dijk's "vicious circles".

MATERIALS REQUIRED

- "Four Stages Leading to Addiction" on newsprint
- "Stages in Process of Drug Use" on newsprint
- "Addiction Characteristics" on newsprint
- "Shifts in Characteristics of Stages of Drug Use" on newsprint
- "Generating Factors" on newsprint
- "Drug Use as Human Behavior" on newsprint
- "Pharmacological Vicious Circle" on newsprint
- "Cerebro-Ego-Weakening Vicious Circle" on newsprint
- "Psychic Vicious Circle" on newsprint
- "Social Vicious Circle" on newsprint
- *Substance-Age Chart*
- *Drugs Demystified* by Helen Nowlis; Chapter 3
- *"Complexity of the Dependence Problem"* by Van Dijk

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	OVERVIEW: MODULE III ● Review the objectives of Module III with the total group. ● Explain the sequential flow of the module by highlighting: - Large group introduction to the content - Small group activities - Lecture presentation by the trainer - Large group discussion ● Introduce the module as follows: In this module we'll be concentrating on finding new ways to consider the phenomenon of drug addiction. It is hoped that this effort will allow us to examine some of the images and assumptions about drug addiction that can impede progress in dealing with problems associated with drug addiction as a dependent behavior. If you look at the descriptive terms of *addict* that we generated in Module II, there is no doubt that there is some confusion in most peoples' minds when they think or say *drug addict, drug addiction, or addiction.* ● Read aloud the terms that were generated by the group in Module II, in an effort to describe an *addict*. NOTE: Be sure that you have posted the terms on the newsprint entitled "ADDICT."
5 minutes	● State the following: - When we use terms such as *drugs, drug abuse, drug use,* and *drug addiction* we need to keep in mind that different people use different substances in different amounts for different reasons

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

under different circumstances. The majority of people do not use substances proscribed by their culture or for reasons unacceptable in their culture. If the majority did, it is probable that the culture would be modified to include such use of such substances. Customs, mores, and laws in general represent consensus in a given culture. Both increasing use of a new drug and its users represent a threat to that consensus.

- To put drug use in perspective, it is necessary to make at least some gross distinctions. These are usually made on the basis of either type of substance used or of different levels of frequency of use.
- Apart from the type of drug used, these differences in the frequency of use are influenced by the personality structure, social factors (including treatment), and probably also by the duration of the state of dependence. *In some cases dependence is consistent with a more or less normal way of life; in others it is not. In the latter case, the clinical term "addiction" may be used. It should be noted that this definition of "dependence" and "addiction" does not include nor exclude physiological mechanisms.* The terms are used in a descriptive way, to characterize behavior or ways of living.
- When we use the term *drug addict* we need to keep in mind that we are observing a state of dependence as a behavioral syndrome that is characterized by the fact that the person concerned cannot live without the drug.

- Write the following on newsprint:

4 STAGES LEADING TO ADDICTION

1. Contact

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	2. Experimentation ● Socially tolerated use ● Integrated mode of use 3. Excessive use ● Incidental excessive ● Periodical excessive 4. Addiction
5 minutes	LECTURE: STAGES OF DEPENDENCE ● State the following: - It is useful not to look at dependence, including addiction, as a separate entity only, but to keep in mind that it must be regarded as the final stage of a process. - We may roughly sketch the natural history of the use of a drug's leading to dependence as follows: 1. The first stage is the *contact* with the drug, which may take place in a medical or a non-medical setting. After one or more contacts the process may come to a halt, or it may develop into the second stage, that of *experimentation*. The initial decision to try a drug has less to do with the drug and its pharmacological properties than with the meaning and the value an individual places on both. Before he has ever experienced the effects of the drug, he knows it only by reputation and hearsay. Virtually all studies of the reasons for initial use agree that curiosity and peer pressure are major motivating factors. Availability of the drug, a setting for use that is perceived as relatively safe, and friends who use drugs are necessary, but not sufficient,

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	factors for initial use. The majority of studies agree that the majority of experimenters with illicit drugs do not become users. Curiosity is satisfied. Status with peers is gained. The effects are not valued, are not worth the risks involved. Other activities are valued more. 2. The stage of *experimentation* may assume different forms as to picture, intensity, and duration, depending on several factors that will be discussed later. After some time has elapsed, the second stage may come to an end, or it may develop into a stage of *socially-tolerated use* that (from a psychiatric point of view) may be called an integrated mode of use; or it may lead to the stage of excessive use. The majority of experimenters do not continue to use, and the majority of those who do continue do so on a casual or occasional basis. The drug is used only when readily available and only in a social context where it is being used. Use is usually spontaneous rather than planned. The major reasons for continued occasional use are primarily social--not too different from those for adults' casual use of alcohol. It facilitates social interaction; it feels good; it is fun. Most casual or occasional users do not become regular users. As an experience and an activity it is not very important when compared to other experiences and activities. 3. The stage of *excessive use* often carries several risks and damages that may be of a physical, psychical, social (interpersonal), economic, legal, moral, etc., nature. What is to be regarded as a risk or a damage depends largely on the prevailing social habits and customs, on the economic and historical situation. The psychiatrist is inclined to speak of *excessive use* when there is the threat of an impairment of social, psychological, or physical functioning. He could label this stage of the drug use process as

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

excessive if actual damage can be demonstrated as being related to the drug habit.

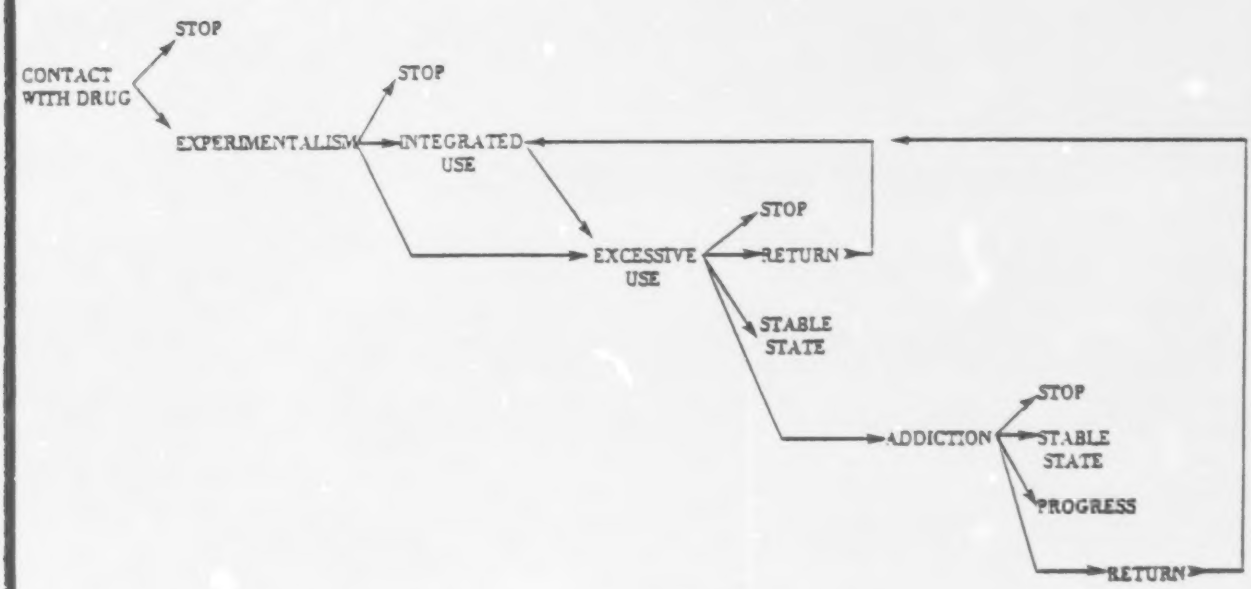
- The stage of *excessive use* as part of a process should be distinguished from *incidental excessive use* and from *periodical excessive use* caused by psychiatric factors like recurring depression or epilepsy. It is a more or less continuous state.

- What is defined as *incidental excessive use* rather than *periodical excessive use* depends on a combination of factors such as the frequency of use, the particular drug used and the point of view of the observer or the judge. *Incidental excessive use* is distinguished from *periodical excessive use* both in terms of the reasons for use and the strength of the need to use. When use becomes either incidental or periodical the concept of psychological dependence is invoked. Such dependence merely means that the individual is unhappy when the drug or the opportunity to use it is not available, and will go out of his way to seek the drug and the opportunity to use it. The reasons for *incidental* or *periodic use* are more diverse, more central to the personality of the user than in *experimental* or *socially-tolerated* use and more related to the pharmacological action of a particular drug, whether it is a stimulant, a depressant, an analgesic, or a substance that changes perceptions of self and environment.

- Only a small minority of *users* become *excessive users*, just as only a small minority of users of alcohol become alcoholics. Although *excessive use* usually implies extremely high frequency of use, it actually covers a range of frequencies. The central factor in *excessive use* is the degree to which use dominates the life of the individual. When major time and thought and energy are devoted to getting the drug, taking the drug, discussing the effects of the drug, associating almost exclusively with others who use the drug, use is considered excessive. When this occurs, the individual can be considered *psychologically dependent* on the drug or, as is increasingly the case, on several drugs rather than a specific drug. *Psychological dependence currently is considered more important than true physiological dependence as the critical factor in most excessive drug use.*

4. In a percentage of cases, *excessive use* can develop into the syndrome of *addiction*, which is a more or less terminal state. *On the other hand, stopping the excessive use, or a return to integrated use, can occur.*

- Write the following on newsprint, using the identical structure displayed below.


STOP
CONTACT WITH DRUG
STOP
EXPERIMENTALISM
INTEGRATED USE
STOP
EXCESSIVE USE
RETURN
STABLE STATE
STOP
ADDICTION
STABLE STATE
PROGRESS
RETURN

STAGES IN PROCESS OF DRUG USE

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	● State the following: If we looked at the stages in the process of drug use it would look like this: Contact with the drug Stop Experimentalism Stop Integrated Use Excessive Use Stop Return Stable State Addiction Stop Stable State Progress Return *NOTE: Point to each item as you say the item.*
5 minutes	● Ask group members if they have questions; respond accordingly. ● Write the folloiwng on newsprint:
	ADDICTION CHARACTERISTICS 1. Damaging to the individual 2. Relatively autonomous 3. Addiction syndrome is self-perpetuating

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	LECTURE: SHIFTING FROM USE TO ADDICTION

- State the following:

  - Addiction, which is the extreme form of dependence and which may be considered an illness, is a syndrome showing three main features:

  1. It is damaging to the individual.
  2. It is relatively autonomous. By this we mean that, whatever complex interplay of factors may have led to the phases of excessive use and addiction, once the boundary has been passed, a relatively stable state has come into being. That state is addiction, which is mainly independent of primary generating causes and conditions. For treatment means, that in the majority of cases, merely removing the initiating factors is not sufficient. Special measures aiming at treating the addiction syndrome as such must be taken.
  3. The addiction syndrome is self-perpetuating. Spontaneous recovery is exceptional. If no help is offered, there is a tendency to further deterioration.

  The courses the process can take in the individual case, the successive stages, and the final state show great variety, depending on the drug involved, the personality structure of the user, and the social context.

- Write the following on newsprint with the identical structure displayed below.

SOME SHIFTS IN CHARACTERISTICS
OF STAGES OF DRUG USE

TIME/MATERIALS | **TRAINER ACTIVITIES OUTLINE**

EARLIER PHASES (CONTACT, EXPERIMENTATION)	LATER PHASES (EXCESSIVE USE, ADDICTION)
More Freedom	Lack of Freedom
Less Risks and Damage	More Damage
Abuse Possible	Abuse Present
No Illness	State of Illness
Operating Factors Linear	Vicious Circles

5 minutes

- State the following:

  During the development of dependence several changes in characteristics of the developmental stages of drug use occur.

- Describe the changes and shifts by stating the following:

  - In the earlier phases (i.e., contact, experimentation) we see more freedom from the drug; less risks and damage to the individual drug user. There is still the potential for possible abuse of the drug by the individual. There is virtually no illness associated with the drug user. Operating factors are linear. In other words, *the drug is used only when available readily and is used only in a social context*. Use is spontaneous rather than planned. The major reasons for continued use are primarily social. Use facilitates social interaction; it feels good; it is fun. As indicated by the chart, most people in the earlier phases do not become regular users. Drug taking is not very important when compared to other experiences and activities in the person's life.

    However, during the later phases (i.e., excessive use, addiction) there is a .

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	lack of individual freedom from the drug. More damage is done to the individual. Abuse not only is possible, it is present. There is a state of illness. The person is engaged in a vicious circle. - In other words, the person probably devotes a lot of time, thought, and energy to getting the drug, taking the drug, discussing the effects of the drug, associating almost exclusively with others who use the drug. The person is considered psychologically dependent on the drug, or, as is increasingly the case, on several drugs (polydrug use) rather than one specific drug. HE IS ADDICTED.
5 minutes	● Ask group members if they have questions regarding the material presented thus far. If so, respond accordingly.
	● Write the following on newsprint: Generating Factors A. Pharmocological effects of the drug B. Personal factors of the user 1. Feelings of discomfort 2. Intense, unpleasant feelings 3. Inability to master intense, unpleasant feelings C. Social meaning and value of a drug and drug-taking D. Environmental influences on the user

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	LECTURE: GENERATING FACTORS

- State the following:

  - Thus far, extensive research has failed to show one single cause that initiates the process of pathological use of drugs. On the contrary, both research findings and clinical work have made it clear that a complexity of causes and conditions give rise to the drug-taking process.

  - We can summarize these factors as follows:

  A. *The pharmacological effects of the drug.*

  We may roughly locate the various drugs on a scale. One one side are the drugs with a strong addictive action (e.g., heroin, morphine, palfium); on the other are those to which an addictive power scarcely can be ascribed (e.g., aspirin, chlorpromazine, laxatives, or even petrol or vinegar). The addictive property of a drug depends on the somatic and psychic influences it exercises. In that way these are connected with the chemical structure is largely unknown. All of the addictive drugs have an influence on the feeling or mode of experience of the user.

  For practical reasons we can classify them as sedating, stimulating, and psychedelic effects.

  In all cases the drug is taken for its desired action. What in a given case is regarded as desired depends on the following factors:

  B. *The personal factors of the user.*

  In this dimension, too, we can make a scale with at its extremes persons who have a strong disposition toward excessive use and addiction, and those who are scarcely susceptible to it.

  The former type can be seen to incline toward a disfunctional use even of non-

or hardly-addictive drugs. Often with these persons a triad of features can be found:

1. Feelings of discomfort, tension, and displeasure can arise easily in them, in case of mild frustrations, or even "spontaneously";

2. These unpleasant feelings are very intense, or nearly unbearable;

3. The absence of possibilities to master, sublimate, and channel such feelings.

The drug may be used to seek relief from the state of tension. Those people *not* disposed toward abuse include those in our culture who are impervious to alcohol, tobacco, tea, coffee, sweets, etc.

The personal factors should not be considered to form an invariable and stable system. Age, for example, is an important modifying factor; during puberty and adolescence, the risk appears to be increased.

Physical and psychiatric diseases with a debilitating influence should also be kept in mind as predisposing factors.

C. *The social meaning and value of a drug and of drug taking.*

Along this dimension, factors like the drug's being accepted in the culture or being considered alien to it play a role (the acceptance or rejection of alcohol or opiates in some Eastern and Western cultures).

Furthermore: 1) the ritualization of the use of a drug, and the social norms, habits, and sanctions governing it, including the legal regulations and jurisdiction; 2) the aura of sensation and thrill; 3) the significance of a drug as a symbol of sturdy, competitive, aggressive masculinity; 4) or of a non-committal, non-aggressive attitude and mode of behavior; 5) the function of a drug or of using drugs as a symbol of differences between groups, classes, and generations (to the group the user is the insider and the non-user is the outsider, while, conversely the user is the outsider in society in general); 6) the function of a drug or of drug-taking as a symbol of a progressive, non-authoritarian attitude.

The social meaning of a drug and of drug-taking is not only important as an incentive to take drugs, but also as a factor that can have an important influence on the effect of a drug. Here lies a connection with the general pharmacological problem of the placebo-effect, and of the difference between reactors and non-reactors.

D. *The environmental influence on the user.*

Influences can be divided into positive factors (leading to a favorable reaction of the person) and negative ones (causing too great, too small, or inadequate stress). The same social situation and influence may be experienced by one person as a positive stimulus, and by another as a heavy burden that he may try to get rid of by using drugs.

- Write the following on newsprint, with the identical structure displayed below:

Drug Use As Human Behavior

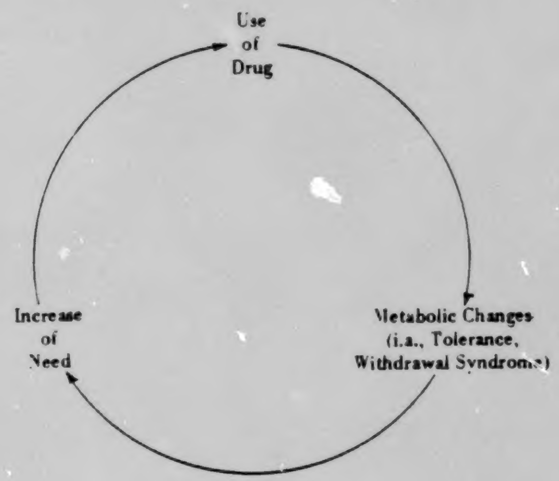
1. Drug use varies from individual, time to time, group to group, culture to culture, generation to generation.

2. No simple relationships exist between cause and effects.

3. Behavior occurs in a social and cultural context.

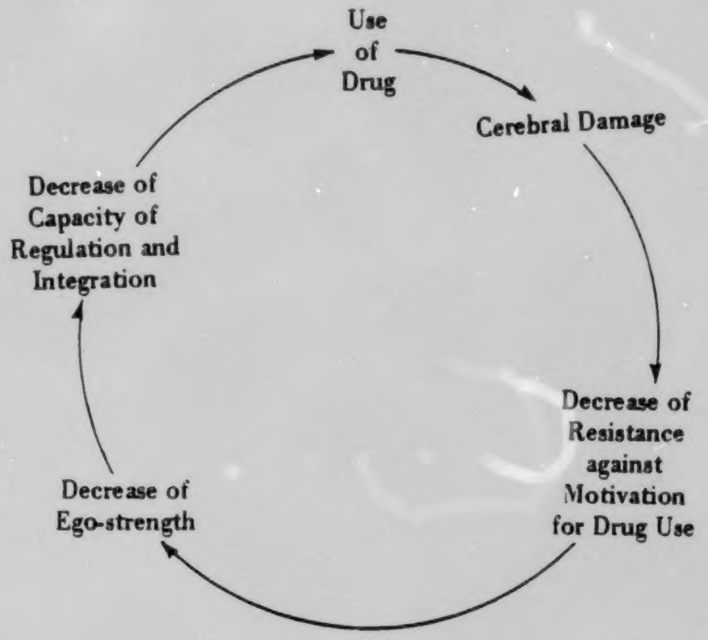
TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	4. Beliefs and perceptions motivate behavior. 5. The behavior of drug user serves some physical, psychological, or social function.
5 minutes	● State the following: - When the drug user is recognized as a person and his integrity is respected, his growth and development can be fostered and he can be helped in dealing with his special problems. - When drug use is recognized as human behavior, then, as behavior, it may be studied with the help of all of the principles that characterize human behavior generally, and with the help of the accumulated wisdom of the social and behavioral sciences. 1. It varies from individual to individual, from time to time in the same individual, from group to group, culture to culture and generation to generation. Different individuals use different drugs in different amounts at different times for different reasons in different social and cultural contexts with different results. 2. There are no simple relationships between cause and effect. As with all behavior which is multiply-determined, patterns of drug use are influenced by many factors: family, school, church, community, peer group, and media. The relative importance of each will depend on the community's definition of its role and on its ability to relate to the needs of its young people. 3. Behavior always occurs in a social and cultural context, and it is often this context that gives it meaning.

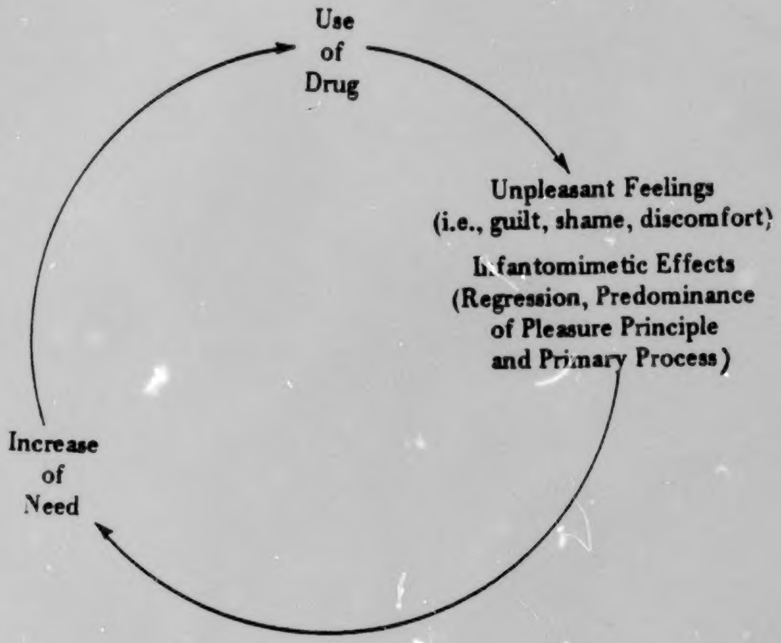
TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	A society's or a group's definition of, and response to, drug use is often more important in determing the problems associated with drug use than the drug use itself. 4. Beliefs and perceptions, regardless of whether they are judged as real or acceptable by others, motivate behavior. 5. Unless a given behavior serves some physical, psychological, or social function it will not persist. If the behavior of drug use persists, evidently it serves one or more functions and fulfills needs.
5 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.
	● Write the following on newsprint, with the structure indicated below.


Use of Drug
Metabolic Changes (i.a., Tolerance, Withdrawal Syndrom[illegible])
Increase of Need

PHARMACOLOGICAL VICIOUS CIRCLE

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	LECTURE: VICIOUS CIRCLES ● State the following: - There is as yet no adequate explanation for this remarkable feature of addiction. However, there are strong indications that an important pathogenic part is played by the mechanism of vicious circles, in which a cause generates a result that in its turn maintains or reinforces the initial cause. In addition, we may distinguish four vicious circles. - Pharmacological investigations have shown that the repeated use of drugs may cause a change in the metabolism of a person. This change may manifest itself in the phenomenon of tolerance, (after prolonged use, an increase of the dose is needed to attain the same effect) and the withdrawal syndrome (a sudden interruption may cause unpleasant and even serious physical and psychological signs and symptoms). - In some types of dependence, the persistant need for the drug and the inclination to increase the dose may be explained on account of these phenomena. Continuation of the use, however, maintains the metabolic change, which in its turn is responsible for the need to use the drug again. Cause and effect influence each other by means of pharmacological mechanisms. This is the reason why we speak of a *pharmacological vicious circle*, as illustrated by the chart.
	● Write the following on newsprint, with the structure indicated.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	 Use of Drug Cerebral Damage Decrease of Resistance against Motivation for Drug Use Decrease of Ego-strength Decrease of Capacity of Regulation and Integration TABLE 5. CEREBRO-EGO-WEAKENING VICIOUS CIRCLE
5 minutes	• State the following: - In some cases the quantitatively and qualitatively excessive use of a drug may have a direct damaging influence on those cerebral functions that form the basis for regulation and integration on the behavioral level. - The outcome is a weakening of the strength of the ego. This means that the personal psychical powers to regulate and control the use are reduced. This, in its turn, implies that the motives leading to the use of the drug get the opportunity to assert themselves more easily. Because of this mutual relationship, one can also speak of a *cerebro-ego-weakening vicious circle*, as indicated by the chart.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	● Write the following on newsprint, with the structure indicated.
	 Use of Drug Unpleasant Feelings (i.e., guilt, shame, discomfort) Infantomimetic Effects (Regression, Predominance of Pleasure Principle and Primary Process) Increase of Need TABLE 6. PSYCHIC VICIOUS CIRCLE
5 minutes	● State the following: - This refers to the effects of dysfunctional use in the mental field. In this case, feelings of guilt and shame, the unpleasant notion that decreasing or abstaining from its use would be better, and the disagreeable perspective of the future, etc., play an important role. The easiest and most effective way to get

rid of these annoying feelings is to take the drug, and in this way, a *psychic vicious circle* is started.

- Moreover, we may point at the infantomimetic effect of the use of drugs. By this we mean a regression to a more infantile form of behaviors with an increase in the affective and instinctive aspects of behavior, and a decrease in the controlling and synthetic functions of the ego. Describing this process in psychoanalytical terms, we may ascertain a shift from the reality-principle and an increasing relative predominance of the primary over the secondary process. Since cause and effect influence each other to and fro, we may assess again a vicious circle in the psychic level.

- Write the following on newsprint in the following manner, with the structure indicated below.

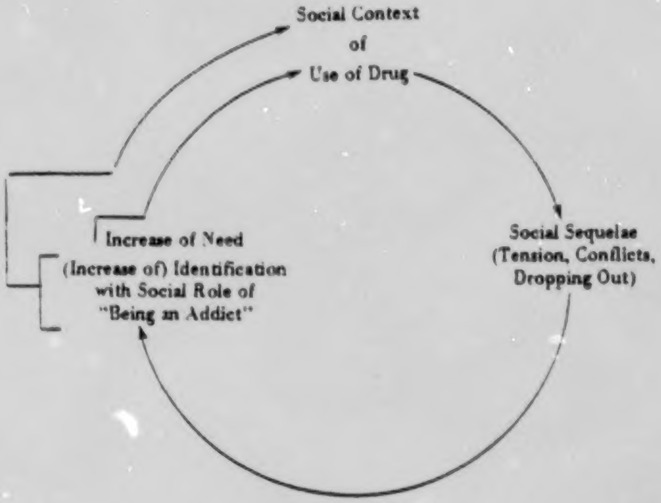

Social Context
of
Use of Drug
Social Sequelae
(Tension, Conflicts,
Dropping Out)
Increase of Need
(Increase of) Identification
with Social Role of
"Being an Addict"

TABLE 7. SOCIAL VICIOUS CIRCLE

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	• State the following: - This circular process is based on the fact that drug addiction has social consequences, which in their turn, reinforce the use of drugs. The social sequelae may be described as a dysfunction and finally, a disintegration within the groups the addict is (or was) functioning in. - This process has harmful effects on the addict. - We may only mention the reproaches of the spouse and other members of the family, the quarrels arising, the distain and and withdrawal of friends and acquaintances, the tensions and conflicts in the occupational sphere and, finally, the dropping out from society. - This isolation and rejection engender in the subject negative feelings, which foster an attitude of "let oneself go into the state of being an addict." This means a fixation of the role behavior that goes with it, and a reinforcement of the identification with a drug-using subculture.
	NOTE: *1. In some drugs (e.g., alcohol) all vicious circles mentioned are present; whereas in others, they are not. In marihuana, for instance, the pharmacological and the cerebro-ego-weakening circuits are lacking.* *2. The original pharmacological, cerebral, psychological, and social factors that give rise to the vicious circles are by no means restricted to the state of addiction only. They may already be demonstrated in the earlier stages of the process of drug use.* What we can see, however, is that the more the process moves to the stage of excessive use,

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	the more the generating factors are becoming circular. *This shift from a linear to a circular mechanism is connected with a developing dis-equilibrium between the operating factor on the one hand, and the capacity to keep up with this operating factor or its effects on the other.* *Finally, when a shift has taken place from linear to circular and when the quantitative influence of the circuits has risen to a critical level, the addictive state has been attained and will be maintained.* 3. *In this progress from more linear to more circular action, the factors mentioned do not work separately. In earlier stages, they may either cooperate and intensify, or conversely, counterbalance and reduce each other. In the later phases, they mostly reinforce each other, which explains the relative autonomy and the self-perpetuating nature of addiction.* 4. *An example of the fact that the factors involved may counterbalance each other may be found in the therapeutic field. It is often possible in the process of treatment to switch over a heroin addict to methadone and to keep the patient on a stable doese of it by supportive psychic and social measures. In some cases, the patients themselves try to decrease their dosage. Whereas, in a non-medical setting, methadone gives rise to addiction with increasing doses in most cases. Here we see that social and personal factors are able to reduce the pharmacological vicious circle.*
5 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

- State the following:
    - Whenever there is concern with deviant or destructive behavior, there is often an attempt to identify physical, psychological, or social background factors characteristics of those who engage in these behaviors, on the assumption that others who share the same characteristics and background are more likely to become involved in the same deviant or destructive behavior. Efforts to prevent, intervene, or isolate may then be concentrated on those so identified.
    - No such factors have as yet been identified clearly as either necessary or sufficient to serve as a basis for reasonably accurate prediction. Availability of drugs, a situation in which drug use is perceived as safe, and association with friends who use drugs seem to be the only factors that can be identified as necessary for drug use. None is a sufficient factor.
    - Biological and medical scientists have searched for physiological, genetic, or biochemical factors. Behavioral scientists have searched for specific character disorders or psychopathology, for arrested stages of growth and development, for influences on development of such factors as broken homes, permissive or laissez-faire parents, patterns of child rearing, social, religious, and political attitudes of parents. Social scientists have sought explanations in terms of deprivation, poverty, poor housing, inadequate educational and occupational opportunities, prejudice and discrimination, as well as such factors as cultural pressures supporting drug use, advertising and content of mass media. What is found is often a function of what was sought.
    - On the whole, differences between users and non-users of this or that drug or of

psychoactive drugs in general are small, though in some cases significant statistically. They are often specific to the sample studied both in terms of socio-economic and cultural characteristics, type of drug used, and pattern of use.

- Just as it was necessary to distinguish among types of drug use, it is even more necessary to distinguish among types of drug users and drugs used. This adds another dimension of complexity to a picture that is already very complex. This complexity presents the greatest difficulties for those who insist on simple, universal answers. Acceptance of such complexity enables one to begin to define a particular problem in a particular community and to begin to solve it.

- It is much easier to address the problems posed by a group of socially- and economically-privileged high school students using marihuana occasionally because they are bored, are experimenting with independence and rebellion as well as drugs, then it is to solve "the drug problem" at a national level.

- It is easier to address the problems created by economically, educationally and socially deprived nine-, ten-, and eleven-year-olds sniffing glue as perhaps the only momentary escape from an almost unbearable existence available to them, than it is to develop nationally a social or educational policy that addresses the problems associated with non-medical drug use.

- Drug users are experimenters, or casual or occasional users or regular users, or they may be periodic or regular heavy users, or complusive users of an increasing array of substances.

1. *Experimenters*. To invoke factors other than social in distinguishing between experimenters and non-users is probably not justified and may even be

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

non-productive. On most psychological and life-history variables, experimenters do not differ significantly from their abstinent counterparts. Some studies would suggest that in one nation, at this point in time, experimenters with cannabis or marihuana tend to be more intelligent, to come from a higher socio-economic background, to be more adventurous, creative, and rebellious than non-users. This would not have been true in the same place ten years ago. Nor is it true, for example, for experimenters inhaling solvents.

2. *Casual or Occasional Users.* As is the case with experimenters, social and chance factors are still predominant with casual or occasional users. Availability, a place perceived as relatively safe, and friends who use or approve of use are key factors, as are the drugs used.

3. *Regular Users.* The lines between occasional and social, and between social and regular users are hard to draw with any degree of precision, especially without reference to specific drugs. Moreover, there is a large group of social users who fluctuate between occasional and regular use. But at the stage of regular use, differences begin to appear between users and non-users. They are still tenuous and still complex, still highly variable.

- The results of one of the few studies that have followed a large, randomly-selected national sample over a period of four to six years, spanning grades X-XII (ages 13-17), and at least two years of post-high-school experience, illustrate this complexity and this variability. In one sample, 2,200 biys in 87 high schools in the United States were followed through their last two years in high school, and as young men through at least two years of post-high-school experience (whether in college, at work or in the military). Those from higher socio-economic levels used more marihuana and

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

substances usually referred to as hallucinogens. The highest socio-economic group used the most barbiturates. They used less alcohol during high school, but after high school their use of alcohol did not differ from that of those from the lower socio-economic status. Those the higher intelligence used more marihuana and fewer cigarettes. Use of marihuana and hallucinogens was greater for those with higher intelligence than with lower. The more intelligent were less likely to use alcohol in high school. They showed the lowest level of barbiturate and heroin use, and amphetamine use was greatest at both the highest and lowest levels of intelligence. At intermediate levels of intelligence there were no clear differences in amphetamine use.

- Higher rates of use of most illegal drugs were found for those from broken homes; and of both legal and illegal drugs for those whose families had moved at least once during the high school years. The more delinquent were substantially more likely to be users of both legal and illegal drugs; but users did not increase their level of delinquency from pre-drug-use levels. There was a strong relationship between use of marihuana, hallucinogens, and amphetamines and political dissent. Both college and non-college students who rated high on measures of dissent used more of these drugs. Involvement with illegal drugs did not have any significant association with level of delinquency or academic performance. Although users tended to have higher rates of delinquency and lower academic performance, these clearly predated drug use.

- One of the strongest relationships was that between drug use of all kinds and size of school: the larger the school, regardless of whether it was in a large city or not, the more drug use.

- Attitudes toward drug use were basically conservative except in the case of marihuana, where they were generally more liberal, but tended to be polarized. Attitudes did not differ among the col-ege lege, civilian-employed, or militazy se segments of the population.

- If this is confusing, it should be. Drug use is complex and confusing. It is only when one pretends that it is not that one makes mistakes. One must consider who uses what drugs and when, if one wishes to help real individuals, and not merely respond to an ill-defined problem.

4. *Compulsive Users.* In characterizing heavy, compulsive users, it is not difficult to distinguish them from those who exhibit other forms of destructive behavior. Many feel that the greatest mistake that can be made is to consider heavy, destructive drug use by young people as something uniquely different from such destructive behaviors as violence or from adolescent suicide, both of which, they point out, are increasing rapidly. Some would go so far as to suggest that preoccupation with drug use at all levels is primarily a mechanism to avoid facing basic social problems, and that adolescent suicide and violence, like destructive drug use, are only manifestations of such basic problems.

- Compulsive drug users are often described as immature, as suffering from various kinds and degrees of psychopathology, as unwilling to face and seek solutions to problems that other people solve, as alienated, as suffering from character disorders. They are people with problems to which they seek to respond through the use of drugs. It is tempting to see them as perverse. It is more constructive to seem them as people with problems with which they cannot cope in socially-acceptable ways.

- Any of the factors that seem to be related to drug use or potential drug use are in

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all probability equally relevant to any of a number of different deviant or destructive behaviors. At the level of prevention of experimentation, if experimentation can be prevented, social and cultural factors are probably more relevant than any personal or psychodynamic characteristics. Informal social attitudes toward the use of any substance--the way in which a society or a group within a society defines the use of the drug as dangerous, daring, forbidden, deviant, destructive to self or society--will influence who uses what drug for what purpose.

- The sociological concept of "dictated deviance," that process by which a society or group defines a certain behavior as a major form of deviance and in the process, channels deviance and dissidence into that behavior, should be considered seriously by those groups or societies in which non-medical or illegal use of specified substances is not yet widespread. To define drug use as a "number one problem" amy contribute to making it one.
- The dependence problem was discussed from the vantage point of clinical psychiatry. Some perspectives were presented that might help you to bring some order in the multitude of facts, hypotheses, and theories brought forward from different fields of science and experience, and to probe the possibilities for further research, all the time keeping an open eye for new discoveries and fresh hypotheses.
- After a brief general description of dependence, it was stressed that dependence, including addiction, is not a separate entity, but that it has to be considered the final stage of a process. *The stages are: contact, experimentation, excessive use, dependence, addiction.*
- In each stage damaging misuse is possible. The process can be stopped in each stage. A return from later to earlier stages is possible.

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- In the individual case it is of paramount importance to diagnose the stage of the process in order to come to a correct assessment of the situation and to offer adequate therapeutic help.

- Display the chart on newsprint entitled: "Generating Factors."

- State the following:

  - Regarding the etiology of dependence, the following models were presented:

GENERATING FACTORS

A. The pharmacological effects of the drug;

B. The personal factors of the user;

C. The social meaning and value of a drug and of drug taking;

D. The environmental influences on the user.

- Display the charts on newsprint entitled:

  - *The Pharmacological Vicious Circle*
  - *The Cerebro-Ego-Weakening Vicious Circle*
  - *The Psychic Vicious Circle*
  - *The Social Vicious Circle.*

- State the following:

  - Several factors are responsible for maintaining the process after contact with the drug is made. The mechanism of vicious circles was discussed. In dependence, in general, four of them can be present:

A. The pharmacological vicious circle;

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B. The cerebro-ego-weakening vicious circle;

C. The psychic vicious circle;

D. The social vicious circle.

- These charts indicate models of four vicious circles. The advantage of looking at the drug user from this perspective is:

  1. The model gives the opportunity to make a better distinction between different types of drugs.

  2. The shift from a linear to a circular mechanism is connected with a developing disequilibrium between the operating factor on the one hand, and the capacity to keep up with it and its effects on the other.

  3. The factors mentioned may cooperate and intensify or, conversely, counterbalance and reduce each other.

- One could conclude that only a multidisciplinary approach using multi-factorial models can, in the long run, bring a solution of the dependence problem.

- What does all this mean? Is it merely an intellectual exercise in futility? Is the problem so complex that paralysis rather than constructive action necessarily must follow? The answer to both questions is "no." The complexities of drugs and drug effects, of drug use and drug users, are paralyzing only if one seeks simple, universal answers to problems posed by what is essentially highly variable human behavior sharing the characteristics of all human behavior. Parents and teachers cope with all kinds of behavior daily. The fact that a drug is involved does not nullify all that is known about living and learning.

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	- Perhaps the greatest obtacle to understanding and responding to behavior involving drugs is the belief that, because a drug is involved, that behavior is unique and requires new research, specially-trained experts, new and special methods of intervention and treatment. - Fortunately, both behavioral scientists and many laymen do possess considerable psychological knowledge and understanding, whether of the scientific or common sense type. Thus, most persons, whether newly-interested in, or perplexed and frustrated by, drug-related problems, actually have a better foundation for beginning to respond to these problems than they may realize.
5 minutes	● Ask participants if they have questions. If so, respond accordingly.
15 minutes	BREAK
45 to 60 minutes	SMALL GROUP DISCUSSION *NOTE: This learning activity allows participants to express their views on substance-abuse-problems, by drawing from their own personal experiences. They should also discuss the implications of the presentation for workers in the field.* ● Divide the large group into smaller groups of approximately eight to twelve individuals. Ask the groups to take the *Resource Manuals* with them. ● Introduce self (first name) and ask participants to identify themselves by stating their first names (before speaking) during the discussion.

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- State the following:
  - The trainer presentation stressed the substance-abuse-problem problems--which were defined as problems in definitions and perception.
  - This group discussion will focus first on the definition problem.
- Ask the group the following question:
  - What problems (or reactions) did you have in defining either *drug, drug abuse, addiction*?
- Focus the discussion on definition problems for approximately 15 to 20 minutes.
- State the following:
  - Let's now focus on the perception problem.

  Ask the group the following questions:
  - What were your reactions (problems) with the perception of an *addict*?
  - What is your experience regarding the dimensions of a *substance user and abuser*?
- Focus the discussion on perception problems for approximately 15 to 20 minutes.
- State the following:
  - We are going to conduct another exercise. The purpose of this exercise is to validate (from your personal experiences) your perception of the substances people use at various age levels.
- Ask the participants to locate the "Substance Age Chart" in the *Resource Manual*.
- State:
  - From your own experience, I'd like each of you to list the substances that people 20 years older than yourself use.

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	Next, I'd like each of you to list the substances that your contemporaries use. Last, I'd like you to list the substances people ten to fifteen years younger than yourself use. ● Stress that listing should consist of actual personal experience and no secondhand accounts. That this is imperative or perpetuation of additional perception problems will develop because of misinformation. ● State: - Using the age charts, list the substances parallel to the user's age (i.e., add 20 years to participant's age for first group). ● Clarify any questions regarding directions. ● College age charts from participants. ● Draw an age chart on newsprint, and fill in substances from charts of participants. ● Discuss chart for 30 minutes, stressing various age levels: - The relationship of this chart to perception problems. ● Retain group age chart for use in the next module. ● Return to large group space.
30 minutes	SUMMARY OF MODULE III AND OVERVIEW OF MODULE IV ● Summarize Module III and explain its relevance to Module IV. ● Answer questions from participants. ● Assign Helen Nowlis and Van Dijk papers to be read overnight. END OF MODULE

Pages 37-51 not included due to author copyright restrictions.
These pages contain the following tables:

- Stages in Process of Drug Use
- Some Shifts in Characteristics of Stages of Drug Use
- Operating Factors in the Etiology of the Process of Drug Use
- Pharmacological Vicious Circle
- Cerebro-Ego-Weakening Vicious Circle
- Psychic Vicious Circle
- Social Vicious Circle

REFERENCES

Nowlis, Helen. *Drugs Demystified* Paris: The Unesco Press, 1975. Chapter 3 .

Van Dijk, W. K. "Complexity of the Dependence Problem. Interaction of Biological with Psychogenic and Sociogenic Factors." In H. M. Van Borg, ed., *Biochemical and Pharmacological Aspects of Drug Use.* Haarlem, The Netherlands: DeErven F. Bohn, 1972, 6-17.

MODULE IV

A SOCIAL AND HISTORICAL CONTEXT FOR UNDERSTANDING SUBSTANCE USE IN THE UNITED STATES

MODULE IV: A SOCIAL AND HISTORICAL CONTEXT FOR UNDERSTANDING SUBSTANCE USE IN THE UNITED STATES

PERSPECTIVE

The purpose of this module is to provide information on and give participants new ways to consider the social and historical development of substance use in this country. This module begins with an exercise that will assist the group to look at the history of prohibitions and stereotypes that have become part of that history. Also this module focuses on historical and social perceptions, misconceptions, laws, and our dealing with those who break those laws.

This module includes:

- Overview of Module IV (5 minutes)
- Total Group Discussion: Stereotypes, Perceptions, and Laws (15 minutes)
- Structured Experience: *The Influence Exercise: The Guaranteed Response* (40 minutes)
- Lecture/Discussion: Early American Drug Use (35 minutes)
- Lecture/Discussion: Early Opiate, Tobacco, Alcohol, Marihuana Use, and Laws (35 minutes)
- Lecture/Discussion: Sniffing, Snorting, Shooting, Smoking, Popping, and Dropping (45 minutes)
- Small Group Activity: *Feelings and Reactions* (30 minutes)

TOTAL TIME: 3 hours, 30 minutes

OBJECTIVES

Using the information presented in Module IV as criteria, at the end of this module, and without the aid of notes, participants will be able to:

1. Identify at least three factors related to the painkilling function of substances (drugs) that lead to the development of a dependent substance-user pattern.

2. Identify at least three factors related to the social-recreational functions of substances (drugs) that lead to the development of dependent substance-user pattern.

3. Identify at least three major events that led to the development of the "intensifying" use of substances during the 1960s.

4. Identify one social and one legal response to substance abuse post-Civil War.

5. Identify one social and one legal response to the use of alcohol.

6. Identify three changes that occurred since 1965 in social and legal responses to substance abuse.

7. Identify at least four perspectives, drawn from history, that represent consequences of the drug laws on certain groups.

MATERIALS REQUIRED

- "Stereotypes, Perceptions, Laws" written on newsprint

- *The Influence Exercise: The Guaranteed Response*

- *"A Very Short History of Some American Drugs Familiar to Everybody"* by Adam Smith

- "Good & Bad" written on newsprint

- "Substances" written on newsprint

- Lecture Outline: "Early American Drug Use" on newsprint
- Lecture Outline: "Opiate, Tobacco, Alcohol, Marihuana Use, and Laws" on newsprint
- Lecture Outline: "Sniffing, Snorting, Shooting, Smoking, Popping, and Dropping" on newsprint
- *"A Short History of Drug Use and Drug Users in the United States"* by Elaine Casey
- Markers, tape and newsprint
- Small and large group meeting space

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	NOTE: Be absolutely sure that you have prepared a lecture outline on newsprint prior to delivering this module. All areas indicated by the paper at the back of this module must be discussed, because subsequent lectures and discussions rely on participants sharing relative familiarity with the chronology. You should read the entire substance history paper in the Trainer's Manual *at least once before giving the lecture.* *It is suggested that you do not vary substantially from material presented in the paper at the back of the module, and that you take care not to include references to the prevalent culture biases other than those indicated in the paper itself.*
5 minutes	OVERVIEW: MODULE IV • Review the objectives of Module IV with the total group. • Explain the sequential flow of the module by highlighting: - Large group introduction to the content - Small group activities - Lecture presentation by the trainer - Large group discussion - Small group exercise • Introduce the module as follows: In discussing the history of substance use in the United States, it is impossible to avoid the word "stereotype." Substance users stereotype the substance they use as "all good." Prohibitionists type the substance users as "all bad." Laws, by their very nature, necessitate someone's making a determination that use of one thing is O.K., while use of another thing is a criminal activity.

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- Sometimes the distinction is so simple as to translate: "O.K. is something I ingest for recreation; criminal is something you ingest because you are a weak person with no moral fiber."

- This has often been the case when one portion of society is making the laws, while another segment of society is enjoying the substance. To Chinese immigrant laborers working to build the transcontinental railroad, smoking opium was relaxation. To early Californians, Chinese opium dens were heathen hotbeds of sin.

The distinction is in the eyes of the beholder. And what he beholds is often filtered through the stereotypes that laws, religions, and societal sanctions have evolved regarding people who are not quite "like us."

Since the time of Columbus, key words have been used to load the argument either against or in favor of substance users and the substances they used. Three hundred years ago, the Catholic church prohibited tobacco smoking in Mexican churches. Thirty years ago, tobacco companies advertised testimonials from people who would "walk a mile for a Camel." Today, the Surgeon General's warning "cigarette smoking is dangerous to your health" is carried on every package of cigarettes.

People still smoke. Times change. People change. People's habits don't always change. The value judgment is in the eye of the beholder.

In this module, we discuss the history of substance use in the United States, and the histories of prohibitions and stereotypes that have become part of that history. The O.K./not-O.K. dichotomy effects our perceptions, misconceptions, laws, and our dealings with people who break those laws.

We are a society that makes the distinction between "good drugs" and "bad drugs," between "social habits" and "criminal habits." Sometimes, those distinctions are based on fact. Sometimes on prejudice, lack of fact, or poor

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	information perceived as fact. Throughout the discussion, you will often hear or use the word "substance" when you expect to hear or use "drug." At this stage in the course, we find it more practical to say "substance" when meaning "anything that alters the natural, unaffected physical and emotional state of the human body." Perhaps that working definition is simplistic. However, it does help eliminate, temporarily the semantic problem of determining just when and where caffeine, nicotine, codeine, cola beverages, and over-the-counter medications start being "drugs." When a single substance can be perceived as O.K. when prescribed by a physician, and not-O.K. when ingested for recreation, a substantial perception problem surely exists. In order to assist you in seeing what I am saying, let's try a quick exercise. ● Write the following on newsprint:
	STEREOTYPES - PERCEPTIONS - LAWS 1. How can stereotypes keep us from perceiving the actual parameters of a problem, and from dealing with it as it truly exists? 2. Do laws affect perceptions, or do perceptions affect changes in laws? 3. When society perceives something as "wrong," how does it relay that disapproval to its legislators, so that legal measures can be taken to punish: the substance, the user, the manufacturer, the distributor?
15 minutes	Ask the group to respond aloud to the questions listed on newsprint. If there is hesitation on the part of the group, then use some of the

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	following activities as examples for discussion: - gambling - smoking - drinking alcohol - participation in a war--hawks and the protestors - public assistance to religions--supported primary and secondary schools - price controls on farm products; on energy resources - the 55 mph speed limit - the illegal conduct of an elected public official ● List the responses of the group to each question on newsprint. ● State the following: Now that we have discussed some of the ways that stereotyping helps the system to function, and prevents it from functioning effectively, complete a short exercise to examine some of the ways that people's stereotypes can be manipulated to affect certain patterns in their behavior.
20 minutes	THE INFLUENCE EXERCISE: THE GUARANTEED RESPONSE ● Ask the participants to locate *The Influence Exercise: The Guaranteed Response* in the *Resource Manual*, page IV-9 . Tell them to read the instructions. ● State the following, after five minutes: Do you have any questions about the exercise? (If so, respond.) You will have 20 minutes to complete the exercise. When you are through, facilitators will list some of the influence-loaded words on newsprint at the front of the room. When

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	completing the sheets, remember that one man's propaganda is another's successful media campaign. ● Have facilitators collect participant exercises and list examples from responses on newsprint at front of room.
10 minutes	● Instruct participants to read the four-page chapter "A Very Short History of Some American Drugs Familiar to Everybody," reprinted from *Powers of Mind* by Adam Smith, which appears in the *Resource Manual*, page IV-3.
	● State the following: Some drugs have been domesticated. When we think of coffee, cola, or aspirin, we don't usually respond with the word "drug." But those products do contain substances that would meet Webster's definition of "chemical substance administered to prevent or cure disease or enhance physical and mental welfare." When someone talks of LSD, PCP, codeine, or heroin, though, most of us do think "drug" first, then specifics about the particular substance second. In the chapter you have just read, Adam Smith says: "In some Muslim countries, you can sit and smoke hashish all day at a cafe, but possession of alcohol will land you in jail; in the United States you can sit in a saloon ingesting alcohol all day, but possession of hashish will land you in jail." Why have we come to accept some substances as part of our lives, and others as allied with the entire spectrum of anti-social behaviors? The next exercises should help us to find some of the agents in our culture that publicize and reinforce the stereotypes--both friendly and alien.
10 minutes	● Tape three pages of newsprint in front of the room. Mark one page "GOOD;" the second, "BAD." The third page should read as follows:

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	SUBSTANCES COFFEE MARIHUANA TRANQUILIZERS HEROIN HALLUCINOGENS COLA DRINKS BEER
	● State the following: The broadcast and print media, social groups, religious sects, political parties, Federal, local and State governments, prohibitionist groups, anti-prohibitionist groups, physicians, and researchers have all used certain terms to indicate subjective distinctions between good and bad drugs: those that are right and wrong for people to use. In the next ten minutes, we will rely on the group's experience with those outside influences to isolate some key words that have been used to describe some substances as "good," and others as "bad." For discussion purposes, let's begin with the impact those varied influences have had on society's perceptions of the listed products and of those people who use them. ● Encourage the group to list the influential sets varying groups have used to influence the community.
	NOTE: Be certain that co-trainers do not add to terms listed. Be aware that some group members may respond negatively to the stereotypes reported by other group members. Try to keep discussion in the third person. *Some group members may feel threatened by their lack of quantitative knowledge*

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	regarding some substances. However, the stereotypes they reveal may be the most valuable in terms of describing a general culture climate. To encourage discussion, you may want to go through the entire group several times, eliciting at least one response from each member of the group.
5 minutes	LECTURE: EARLY AMERICAN DRUG USE ● State the following: - "American opinion has always included some opposition to the non-medical use of any drug including alcohol and tobacco. From colonial times through the Civil War, abstentionist outcries against alcohol and tobacco sporadically provoked prohibitory legislation. One 19th century pamphleteer advised against the use of any drink 'which is liable to steal away a man's sense and render him foolish, irascible, uncontrollable and dangerous.' Similarly, one 19th century observer attributed *delirium tremens*, perverted sexuality, impotency, insanity and cancer to the smoking and chewing of tobacco. - "Despite such warnings, alcohol and tobacco use took deep root in American society. De Tocqueville noted what hard drinkers the Americans were, and Dickens was compelled to report that 'in all the public places of America, this filthy custom (tobacco chewing) is recognized.' Nevertheless, the strain in our culture opposed to all non-medical drug use persisted" (National Commission on Marihuana and Drug Abuse, 1972). - Until the late 1800s, abstentionists and prohibitionists had a relatively easy task in identifying the substances Americans used for recreation. Tobacco users and alcohol drinkers were conspicuous. Even the opium dens of the west coast were well known, and opium could be purchased easily and was free from any State or Federal government controls. - Until the Federal Controlled Substances Act was passed by Congress in 1970, anti-substance legislation was hard put to keep pace with (or even categorize) the apparently

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	endless variety fo natural substances and preparations, multi-substance compounds, synthetic derivatives and "improvements" on the natural which were adopted by varying subcultures in the search for a new high. - Physician-prescribed medications, once used for legitimate treatment, came into use as alternatives to illicit substances. Elementary school children got high with inhalants. Students, housewives, and truck drivers found prescription and black market sedatives and amphetamines. Even LSD was no longer just "acid." When LSD-25 was outlawed, it was replaced by DMT, psilocybin, nutmeg, morning glory seeds, peyote, mescaline, PCP, STP, and other hallucinogens not yet prohibited by State and Federal legislatures. - In short, the variety of 20th century substances with potential for abuse confounded the abolitionist/prohibitionist efforts of the 1960s and early 1970s. And the crazy-quilt patterns of regulatory legislation generated reflected that confusion. - The resourcefulness of those determined to get high was remarkable. When one hallucinogen was outlawed, another took its place. With law enforcement agencies concentrating on *dealers* of marihuana and hashish, and putting more energy into locating users and sources of *heroin*, the "weekend" alcohol drinker had a chance to try marihuana and cocaine. With the alcohol consumption age set at age 18 or 21 in most states, younger Americans came to have increasingly easier access to marihuana, cocaine, illicit prescription drugs, and PCP. ● State the following: I am going to present an overview of the history of drug use in this country starting with the explorers.
20 minutes	1. *The Explorers* - The 15th and 16th century explorers were the first people in the Americas to have a multi-substance culture.

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	- "The European explorers from Columbus on found other (in addition to alcohol) mind-affecting drugs, and brought them home. Tobacco was discovered on Columbus' first voyage. Cocaine was found in large areas of South America. Caffeine and LSD-like drugs were found scattered all over the world. The Europeans not only adopted nicotine and caffeine but spread them everywhere. They also imported opium. In a remarkably short space of time, western Europe was converted from an alcohol-only culture to a multi-drug culture" (Brecher, 1972). - In 1575, the Catholic Church in Mexico passed a rule forbidding tobacco smoke in church. - Spanish settlers in Mexico found Incas using peyote in religious ceremonies. The Incas also chewed leaves from the Erythroxylon coca plant (the source of cocaine). Spaniards encouraged the Indians' cocaine habit, but attempted to end the use of hallucinogens in religious rituals. They had little success. Some Indian tribes in both North and South America still continue to use peyote and mescaline. Using the argument of freedom of religion, the Native American Church has put sufficient pressure on the United States Federal government that American Indians are still allowed limited use of hallucinogens in their religious practices. - *Cannabis sativa* was introduced to Chile by Spanish conquerors in 1545. 2. *1770 to 1825.* - Cannabis (hemp) and tobacco were major export crops for Colonial farmers. - The Jamestown settlers brought cannabis to Virginia in 1611 and cultivated it for its fiber. Marihuana was introduced into New England in 1629. From then until after the Civil War, the marihuana plant was a major crop in North America, and played an important role in both colonial and national economic policy.

- George Washington was growing hemp in 1765 at Mount Vernon, presumably for its fiber, though it has been argued that Washington was also concerned with increasing the medicinal or intoxicating potency of his marihuana plants (Brecher, 1972).

- 1775: Hemp plantations were established in Kentucky, Mississippi, Georgia, California, South Carolina, and Nebraska, continuing until the mid-1800s.

- Alcohol, tobacco and caffeine were the substances used by most Americans until the Civil War era.

3. *Opium*

- Opium was brought to the United States in the early 1800s by Chinese immigrant laborers working on the trans-continental railroad. Opium smoking was legal and there were no legal restrictions on opium purchasing.

- Opium use was fashionable among European writers. In 1821, Thomas De Quincey's *Confessions of an Opium Eater* was published. The book was popular, and could well have lead many people to experiment with opium.

  In part, the book said:

  "... I do not readily believe that any man, having once tasted the divine luxuries of opium, will afterwards descend to the gross and mortal enjoyments of alcohol. I take it for granted:

  > 'That those eat now who never ate
  > before, and those who always ate
  > now eat the more.'

  "... What I contemplated in these Confessions was to emblazon the power of opium--not over bodily disease and pain, but over the grander and more shadowy world of dreams.

  "... A man who is inebriated, or tending to inebriation, is and feels that he is, in a condition which calls up into supremacy the merely human, too often the brutal part of his nature; but the opium-eater... feels that the diviner part of his nature is paramount--that is, the moral affections are in a state of cloudless sernity, and high over all the great light of majestic intellect" (De Quincey, 1821).

- De Quincey later wrote *Miseries of Opium*, but the book, which told of his experiences as an opium addict, was never as popular as the *Confessions*.

- Use of opium in the U.S. was primarily medicinal in the first half of the 19th century.

- 1832: a physician wrote this about medical use of opium:

  "'There is scarcely a disease in which opium may not, during some of its states, be brought to bear by the judicious physician with advantage.'" [But he cautioned against its indiscriminate use when other drugs are available.] "'When it is thus used, it seldom fails to lay the foundation for a long train of morbid symptoms, which sooner or later terminate in all wretchedness, which disease is capable of inflicting. Yet, this drug is in use every day, particularly among the better circles of society, and the softer sex'" (Brecher, 1972).

- Patent medicines sold in the United States were a primary source of pure opium. The medicines claimed to cure "female problems," "nerves," "sleeplessness" and other self-diagnosed ailments. They were subject to no Federal or State controls, were available over-the-counter and helped contribute to a large population of middle-class, white, female addicts.

4. *Morphine*

- Morphine was separated from opium in the early 1800s and soon replaced opium in patent medicines.

- Physicians believed the new opium derivative to be non-addicting, and hoped that it could actually cure opium addiction in patients.

Doctors prescribed the new opiate readily. Prevalent medical opinion held that the addiction process occurred in the individual's stomach, and that ingestion of an opiate was responsible for the addiction. The hypodermic needle and syringe were introduced in 1850--greeted as a boon by physicians who hoped to use morphine injections to kill pain, but believed that the injection process itself would eliminate the addiction problem.

- Morphine was used commonly as a pain killer during the Civil War. So large a number of soldiers became addicted as a result of the opiate given them for battle injuries that the post-war morphine addiction prevalent among veterans came to be known as "Soldier's Disease."

- Late in the 1800s, morphine was prescribed commonly as a substitute for "alcohol addiction," with the practice continuing until late in the 1930s.

- Dr. J. R. Black, in a paper entitled "Advantages of Substituting the Morphia Habit for the Incurably Alcoholic," published in the *Cincinnati Lancet-Clinic* in 1889, had the following praise for morphine in alcoholism treatment:

> [Morphine] "is less inimical to healthy life than alcohol...[It] calms in place of exciting the baser passions, and hence is less productive of acts of violence and crime; in short... the use of morphine in place of alcohol is but a choice of evils, and by far the lesser... On the score of economy the morphine habit is by far the better. The regular whiskey drinker can be made content in his craving for stimulation, at least for quite a long time, on two or three grains of morphine a day, divided into appropriate portions, and given at regular intervals. If purchase by the drachma at fifty cents this will last him twenty days."

- Late 1880s: Dr. William Halsted, one of the founders of Johns Hopkins School of Medicine, discovered that cocaine injected near a nerve

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produces a local anesthesia. Halsted himself used cocaine and later reported himself to be a "cocaine addict." He later "controlled" his cocaine habit by morphine injections, and lived until 1922 on a maintenance dose of 90 milligrams of morphine daily.

- 1885: John Styth Pemberton of Atlanta, Georgia, began manufacture of a patent syrup he called "Coca-Cola." The syrup contained extract of coca leaves (cocaine) and caffeine. The cocaine was part of Pemberton's formula until 1906 Pure Food and Drug Law was enacted. The caffeine is still part of the formula.

5. *Early Cocaine Use*

- 1844: Cocaine alkaloid was first isolated, in pure form, from coca leaves.

- 1883: Dr. Theodor Aschenbrandt, a German army physician, gave pure cocaine to Bavarian soldiers during field maneuvers. Positive results were reported, including extended ability to endure fatigue.

- 1884: Sigmund Freud experimented on himself with 50 milligrams of cocaine. Freud prescribed cocaine to relieve the pain of a friend who was then addicted to morphine, and sent some cocaine to his own fiance, to "make her more lively." For the next three years, Freud used cocaine occasionally to relieve his own depression.

6. *Marihuana and Hashish*

From 1850 until 1942, the *United States Pharmacopeia* listed marihuana, under the name "Extractum Cannabis" as a legitimate medicine.

- In 1851, the United States *Dispensory* reported the use of cannabis extract in treating "Neuralgia, gout, rheumatism, tetanus, hydrophobia, epidemic cholera, convulsions, chorea, and hemorrage."

- 1876: The *Illustrated Police News* featured a drawing of a "hasheesh hell" on Fifth Avenue in New York City.

- Late 1800s: Hashish candy was being sold in Baltimore, Maryland, candy stores. Dr. Gregory Wheelock Grover, in his book *Shadows Lifted or Sunshine Restored in the Horizon of Human Lives: A Treatise on the Morphine, Opium, Cocaine, Chloral and Hashish Habits*, admitted purchasing a box of the candy in Baltimore. Determined to test the product on himself, Dr. Grover took "a full dose... [then the drug] manifested its peculiar witchery with scarcely prelude or warning." At the time, he was dining with several friends, and told them of the peculiar sense of well-being which had come over him:

  > "It is undoubtedly here a day of jubilation or of something in the way of celebration. You perceive that the tables are set with golden plate, that the waiters all seem to be dressed in velvet costumes, and that hundreds of canary birds are singing in gilded cages. It must be a celebration of a good deal of magnitude, as the many bands of martial and orchestral music seem all to be playing at once."

7. *Patent Medicines*

- The opiates (opium and morphine) were found in patent medicines until passage of the Pure Food and Drug Act in 1906.

- Largely as a result of the patent medicines and physicians who prescribed opiate medications for female disorders, women became the largest class of opiate-dependent persons during the late 19th century.

- "In addition to opium and morphine in medicines the extent to which alcohol-drinking by women was frowned upon may also have contributed to the excess of women among opiate users. Husbands drank alcohol in the saloon; wives took opium at home" (Brecher, 1972).

8. *Early Anti-substance Laws*

- 1872: California passed the first anti-opium law. "The administration of laudunum, an opium preparation, or any other narcotic

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	to any person with the intent thereby to facilitate the commission of a felony" now was a felony. - 1874: Connecticut passed the first state law declaring a "narcotic addict" incompetent to attend to his personal affairs, and requiring that addicts be committed to state mental asylums until they were cured of their "addictions." - 1877: Nevada passed the first state law to prohibit opium smoking. Opium was to be dispensed only with a physician's prescription. - 1881: California passed a law outlawing opium dens. Opium smoking in private residences was still legal. - 1881: California was the first state to establish a separate bureau to enforce narcotic laws. - 1887: Territory of Oregon passed the first comprehensive anti-substance law: No person could sell, give away, or possess any opium, smoking opium, morphine, cocaine, or chloral hydrate except on the prescription of a physician. - 1905: Connecticut passed a law requiring a physician's prescription for sale of cocaine. In 1913, the law was amended to include opium, morphine, and heroin.
10 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.
	● State the following: - In terms of a summary related to this country's early legal response to drugs it appears that the early state laws generally restricted or prohibited possession of substances without considering whether those substances could have significant medical use.

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	- The laws were concerned with the way in which drugs could be sold. They did not set standards for examining their legitimate use by physicians. Doctors continued to prescribe opiates (morphine and opium) and cocaine for varied ailments; over-the-counter patent medicines containing morphine, heroin, and opium were still legal.
20 minutes	LECTURE: EARLY OPIATE, TOBACCO, ALCOHOL, AND MARIHUANA USE AND LAWS ● Continue your lecture following the pre-proposed outline. ● State the following: 9. *Heroin, the Best Opiate* - Heroin, an opium derivative, was first produced commercially by the Bayer Company in Germany in 1898. - Heroin was advertised as a potent painkiller, with none of the addicting properties of morphine and opium. - Physicians often prescribed heroin to cure morphine and opium addiction. - Importing opium for the manufacture of heroin was legal until 1925. 10. *The Federal Pure Food and Drug Act* - 1906: The Pure Food and Drug Act was passed. The Act required manufacturers to label all products containing opium, morphine, and heroin. Passage of the Act resulted in cocaine's being removed from Coca-Cola. *This was the first Federal legislation to exert any form of control on the use or distribution of drugs.* 11. *The Harrison Narcotic Act* - The Act was passed in 1914. - Full title of the Act is: "An Act to provide

for the registration of, with collectors of internal revenue, and to impose a special tax upon all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives or preparations, and for other purposes."

- The Harrison Act was not a prohibition, but a taxing vehicle allowing the marketing of opium, morphine, heroin, and other drugs on the prescription of a physician who had paid for a license. The preparations could be manufactured only by licensed firms and dispensed by pharmacists who, again, had paid for their licenses.

- Patent medicine manufacturers were exempt from the licensing and tax provisions of the law, provided that their preparations contained not more than two grains of opium, not more than 1/4 grain of morphine, or not more than 1/8 of a grain of heroin in one avoirdupois ounce.

- "Far from appearing to be a prohibition law, the Harrison Narcotic Act on its face was merely a law for the orderly marketing of opium, morphine, heroin, and other drugs--in small quantities on a physician's prescription. Indeed, the right of a physician to prescribe was spelled out in apparently unambiguous terms: "Nothing contained in this section shall apply...to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice only.' Registered physicians were required only to keep records of drugs dispensed or prescribed. It is unlikely that a single legislator realized in 1914 that the law Congress was passing would later be deemed a prohibition law.

- "...After passage of the law, this clause ('in the course of his professional practice only') was interpreted by law-enforcement officers to mean that a doctor could not prescribe opiates to an addict to maintain his addiction.

- "Since addiction was not a disease, the argument went, an addict was not a patient, and opiates dispensed to or prescribed for him by a physician were therefore not being supplied 'in the course of his professional practice.' Thus a law apparently intended to ensure the orderly marketing of narcotics was converted into a law prohibiting the supplying of narcotics to addicts, *even on a physician's prescription.*

- "Many physicians were arrested under this interpretation, and some were convicted and imprisoned. Even those who escaped conviction had their careers ruined by the publicity. The medical profession quickly learned that to supply opiates to addicts was to court disaster" (Brecher, 1972).

- For all purposes, opium and cocaine could no longer be gotten legally, in quantity, by the user on the street. As licit sources became more controlled, new illicit channels opened to supply users. Use of narcotics (including cocaine, mistakenly labeled a narcotic by Congress in the 1914 act) continued at relatively the same level at prior to the act's passage.

- "By fixing severe limits on the amount of opiate a patent medicine could contain, and by otherwise prohibiting the traffic in opiates except for medicindal purposes, the (Harrison Act) abolished the legitimate traffic. When the Supreme Court ruled in the early 1920s that prescriptions for addiction were not legitimately medical practice, the interpretation meant simply that addiction thereby became a federal crime...

- The court thus lowered narcotics use into the underworld, forcing addicts to migrate to the urban centers of illicit supply. It also forced formerly decent and responsible citizens who had acquired an unfortunate habit to become aggressive and violent criminals. It made addicts conform to the image of nonscience; as they robbed or cheated or prostituted themselves to support the illicit price, they did indeed become debauched, corrupt, and depraved. In 1923, as many as 75 percent of the women in federal peniten-

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tiaries were Harrison Act prisoners" (Clark, 1976).

- In 1918, just three years after the Harrison Act went into effect, a study by a Congressional committee (which members included Dr. A. G. Du Mez, Secretary of the United States Public Health Service) released these findings:
  - Opium and other narcotic drugs (including cocaine) were being used by about a million people.
  - The "underground" traffic in narcotic drugs was about equal to the legitimate medical traffic.
  - The "dope peddlers" appeared to have established a national organization, smuggling the drugs in through seaports or across the Canadian or Mexican borders.
  - The wrongful use of narcotic drugs had increased since passage of the Harrison Act. Twenty cities, including New York and San Francisco, had reported such increases (Brecher, 1972).
- As a result of those findings, Congress responded with measures to strengthen the Harrison Act. In 1924, a law was enacted prohibiting importation of heroin *for any purpose*, including medical use. Still the nation was finding that ridding itself of heroin would require considerably more than legislation.
- "The 1924 ban on heroin did not deter the conversion of morphine addicts to heroin. On the contrary, heroin ousted morphine almost completely from the black market *after* the Law was passed" (Brecher, 1972).

12. *The Tobacco Prohibition Movement*

- Until the first decade of the 20th century, tobacco was usually confined to smoking in pipes and cigars, chewing, and inhaling snuff. Cigarettes as we know them today began to appear in the late 19th century, gaining wide popularity some 20 years later. The new cigarettes were made of a mild, Virginia tobacco; they were smaller, paper-wrapped and more amenable to people, especially women. People tried them, liked them, adopted the habit. This new fondness, aided by public outcries against the foul cuspidor, helped confirm Americans in the tobacco smoking habit.

- "The explosive increase in cigarette smoking after 1910 can...be attributed in part to the public-health campaigns of that era against the *chewing* of tobacco and its inevitable accompaniment, the cuspidor. The sputum of tobacco chewers, according to repeated public-health warnings, spreads tuberculosis and perhaps other diseases. Most of those who gave up tobacco chewing no doubt turned instead to cigarette smoking. The ashtray replaced the cuspidor, and lung cancer replaced tuberculosis as the major lung disease" (Brecher, 1972).
- Anti-cigarette leagues flourished. Patterning their efforts on the anti-saloon leagues then lobbying throughout the country, these tobacco prohibitionists had some measure of success. By 1921, the year after alcohol prohibition, 14 states had laws prohibiting cigarettes, and 92 anti-cigarette bills were under consideration in 28 more state legislatures. But people continued to smoke, and the last statewide cigarette prohibition law was repealed in 1927. Only laws concerned with cigarette sale to minors were retained.
- Not only did most states prohibit sale of cigarettes to minors, they also meted out penalties sometimes so severe as to make the whole tobacco prohibition approach a source of ridicule for the decades of the future.
    - "A Florida law made it illegal for anyone under the age of 21 to smoke cigarettes. It was also illegal in Florida to provide anyone under 21 with a cigarette, a cigarette wrapper, or a substitute; a 21-year-old caught in possession of a cigarette could be hauled into court and compelled to

testify concerning its source...

- "In Maine an *offer* to sell cigarettes to a minor was punishable... In Massachusetts snuff and cigars were forbidden to young people under 16; the ban against cigarettes continued until 18... In Pennsylvania, a minor who refused to divulge the source of cigarettes or cigarette paper could be fined, imprisoned, or certified to the juvenile court; refusal to serve as an informer against his cigarette supplier also made a child a criminal in South Carolina.

  "These laws led, of course, to ridicule and contempt on the part of law-defying young people" (Brecher, 1972).

13. *Alcohol Prohibition: The 18th Amendment*

- The Eighteenth or "Prohibition" Amendment passed both houses of Congress in December 1917, and was ratified by three-fourths of the 48 state legislatures 13 months later. From 1920 until 1933, the manufacture, sale, and consumption of alcohol was prohibited in the United States.

- However, as with tobacco, the opiates, and cocaine, legislation failed to create a general climate of abstention.

  "Alcohol remained available during Prohibition. People still got drunk, still became alcoholics, still suffered *delirium tremens*. Drunken drivers remained a frequent menace on the highways... The courts, jails, hospitals, and mental hospitals were still filled with drunks . . .

- "Instead of consuming alcoholic beverages manufactured under the safeguards of state and federal standards...people now drank 'rotgut,' some of it adulterated, some of it contaminated. The use of methyl alcohol, a poison, because ethyl alcohol was unavailable or too costly, led to blindness and death; 'ginger jake,' an adulterant found in bootleg beverages, produced paralysis and death. The disreputable saloon was replaced by the even less savory speakeasy. There was a shift from relatively mild light wines and beers to hard liquors--less bulky and therefore less hazardous to manufacture, transport, and sell on the black market. Young people--and especially respectable young women, who rarely got drunk in public before 1920--now staggered out of speakeasies and reeled down the streets. There were legal closing hours for saloons; the speakeasies stayed open night and day. Organized crime syndicates took control of alcohol distribution, establishing power bases that (it is alleged) still survive. Marihuana, a drug previously little used in the United States, was first popularized during the period of alcohol Prohibition... and ether was also imbibed" (Brecher, 1972).

- In spite of vigorous federal efforts to enforce the 18th Amendment, the alcohol prohibition concept proved unenforceable.
- The 21st Amendment repealing prohibition passed Congress in February 1933. It was ratified by the required number of states in less than ten months.
- The 21st Amendment returned to individual states the power to retain statewide alcohol prohibition, and made it a federal offense to ship alcoholic beverages into a dry state. But the states, too, had learned how impossible it was to keep citizens from drinking. One by one, each repealed its statewide anti-alcohol legislation, with Mississippi the last state to surrender--in 1966.

14. *Early Marihuana Use*

- Recreational use of marihuana became popular during and immediately following the years of alcohol prohibition.
- "[In New York City] marihuana 'tea pads' were established about 1920. They resembled opium dens or speakeasies except that prices were very low; a man could get high for a quarter on marihuana smoked in the pad, or for even less if he bought the marihuana at the door and took it away to smoke.

"Most of the marihuana, it was said, was harvested from supplies growing wild on Staten Island or in New Jersey and other nearby states: marihuana and hashish imported from North Africa were more potent and cost more. These tea pads were tolerated by the city, much as alcohol speakeasies were tolerated. By the 1930s there were said to be 500 of them in New York City alone" (Brecher, 1972).

- In 1926, two New Orleans newspapers, the *Item* and *Morning Tribune*, published a series of "exposes" of the marihuana menace. The papers reported that sailors from Cuba and the South American countries were importing large quantities of the herb into New Orleans and the marihuana smoking had become widespread, even among children.

- "The Waif's Home at this time, was reputedly full of children, both white and colored, who had been brought in under the influence of the drug. Marijuana cigarettes could be brought almost as readily as sandwiches."

- In 1927, Louisiana passed a law providing for a $500 fine or six months' imprisonment for sale or possession of marihuana.

- After passage of the 1927 law, Louisiana residents began growing cannabis, due to the limited amounts of marihuana which could be smuggled into New Orleans.

- "The first large growing crop in the city [New Orleans] was found in 1930 and its value estimated at $35,000 to $50,000... In 1926 about 1,200 pounds of bulk weed were seized, along with considerable quantities of cigarettes. On one farm, 5 1/2 tons were destroyed and other farms yielded cultivated areas of about ten acres...One resident of the city was found growing 100 large plants in his backyard" (Brecher, 1972)

- However, marihuana prohibitionists continued their campaign. In 1929, Colorado passed anti-marihuana legislation aimed at curtailing the habits of Mexican laborers who, being imported to work in the state's beet sugar fields, brought cannabis supplies north with them.

15. *The 1930s: Anti-Marihuana and Other Drug Legislation*

- On January 1, 1932, the Treasury Department's newly-formed Federal Bureau of Narcotics took over enforcement of Federal anti-opiate and anti-cocaine laws. The fact that the Bureau had no actual legal jurisdiction over marihuana failed to deter Commissioner Harry J. Anslinger from lobbying to include cannabis in future federal legislation.

- Shortly after Commissioner Anslinger's appointment, the National Conference of Commissioners on Uniform Drug Laws submitted a draft of a "Uniform Anti-Narcotics Act" which the Conference suggested for adoption by individual State legislatures. The text of the model law did not mention inclusion of a ban on marihuana, but did offer states an optional supplementary provision restricting traffic in what was referred to as "Indian hemp."

- By 1937, the District of Columbia and 46 states had adopted some form of legislation against marihuana. In most of those states, "marihuana was subject to the same rigorous penalties applicable to morphine, heroin, and cocaine, and was often erroneously designated a narcotic" (Brecher, 1972).

- The July 1937 issue of *American Magazine* ran this marihuana scare story, co-authored by Commissioner Anslinger:

  "An entire family was murdered by a youthful marihuana addict in Florida. When officers arrived at the home they found the youth staggering about in a human slaughterhouse. With an ax he had killed his father, mother, two brothers, and a sister. He seemed to be in a daze...He had no recollection of having committed the multiple crime. The officers knew him ordinarily as a sane, rather quiet young man; now he was pitifully crazed. They sought the reason. The boy said he had been in the habit of smoking something with youthful friends called 'muggles,' a childish name for marihuana."

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	- In 1937, Federal Treasury Department officials submitted a proposal to Congress that became the 1937 Marihuana Tax Act. The Act did not actually ban marihuana but, like the Harrison Narcotic Act of 1914, did recognize the potential medical uses of the substance while imposing a tax on those involved in distribution. Members of the medical community, including physicians, dentists, veterinarians, were required to pay a licensing fee of $1.00 per year, which granted them the right to prescribe cannabis to patients. Druggists dispensing the substance would pay a $15.00 annual licensing fee, with marihuana growers taxed at $25.00 per year, and importers, manufacturers, and compounders required to pay $50.00 annually to continue in business. Only nonmedical and untaxed sale or possession of the substance was outlawed. - At this time, the only patent medicine use for cannabis was in preparations of corn plasters or corn removers. In general, manufacturers elected not to register under the tax, and stopped including cannabis in their preparations. - In 1937, Congress passed a schedule of increased penalties for second, third, and subsequent offenses against existing drug laws. Penalties to previous offenders for selling, importing, or exporting narcotics then defined as the opiates, cocaine, and cannabis were raised to a maximum of 20 years in jail or $10,000 in fines. - In 1939, Congress again tightened drug-related penalties through a vehicle seizure law, which allowed for confiscation of any vehicles used for illicit transport of drugs.
10 minutes	● Ask group members if they have questions about the material presented thus far. If so, respond accordingly.

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5 minutes	● State the following: - In terms of a summary related to this country's early legal response to marihuana it appears that: "Marihuana had been included with the opiates (opium, morphine, heroin) and cocaine in early anti-drug laws. "Since 1937, restrictive legislation on marihuana has increased in quantity and severity. Most state marihuana laws specified that marihuana penalties should be the same as heroin penalties. Thus, as heroin penalties were escalated through the decades, marihuana penalties rose automatically. Nineteen states, moreover, made no distinction between mere possession of one marihuana cigarette and the sale of large quantities of heroin. Under both Federal law and the laws of many states...the giving or furnishing of a narcotic drug or of marihuana was included in the definition of 'sale'" (Brecher, 1972). - As recently as 1970, these state penalties were in force: ● In Georgia, sale of marihuana to a minor was punishable by life imprisonment, even if it was a first offense... A second such offense was punishable by death. ● In Illinois, the penalty for a first-sale offense was not less than ten years and as much as life. A mandatory life sentence was in effect for a second-sale offense. These penalties remained in effect after a 1968 amendment to the law reduced the penalties for possession of small amounts. ● In Louisiana, anyone over 21 years of age possessing marihuana was subject to a mandatory minimum sentence of five years at hard labor for a first offense. An adult selling marihuana to another adult was subject to a minimum mandatory sentence of ten years at hard labor and a

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	maximum sentence of 30 years at hard labor and could draw a death sentence. No suspended sentence or probation was permitted for any sale offenses or for second-possession offenses. • In Massachusetts, it was a felony punishable by not more than five years in prison to be in a place where marihuana was kept or deposited, or to be in the company of anyone known to be in illegal possession of marihuana. • In Missouri, the judge could hand down a life sentence for a second-possession offense or a first-sale offense... If the buyer were a minor, a death sentence was possible for a first-sale offense... • In Utah, a life sentence was possible for a first marihuana sale offense or for a second possession-with-intent-to-sell offense. - In 1951, the federal government set mandatory minimum sentences for *all* violations of marihuana laws. Marihuana was not classified with the "narcotics" (opium products and cocaine) by the Federal government. - In 1956, Federal mandatory minimum penalties were raised: • minimum of two years in jail for first possession offense • minimum five years in jail, with no parole, probation, or suspended sentence allowed--for second-offense possession • minimum five years in jail for first-offense sale • minimum ten years in jail for second selling offense • identical penalties for marihuana and opium/morphine/heroin offenses
45 minutes	• Continue your lecture, following the pre-prepared outline.

LECTURE: SNIFFING, SNORTING, SHOOTING, SMOKING, POPPING, AND DROPPING

- State the following:

16. *Legislation Controlling Opium Products*

- 1942: Federal opium poppy control act required a license of anyone growing opium poppies within the United States.

- 1944: Federal synthetic opiates law included isonipecaine (Demerol®) under previous definitions and restrictions of narcotic drugs.

- 1946: Legislation controlling other synthetic drugs went into effect. This defined a new comprehensive class of drugs, the "opiates," which has since been expanded to deal with a number of synthetic substances, including methadone, under narcotic control laws.

  For purposes of this particular act, "opiates" were defined as "any drugs found by the Secretary of the Treasury, after due notice and opportunity for public hearings, to have an addiction-forming or addiction-sustaining liability similar to morphine or cocaine."

- 1956: Federal Narcotic Control Act set minimum mandatory penalties for violations of laws controlling marihuana and the opiates (see above).

  Also, under the Act, anyone convicted of a state or federal law related to marihuana or narcotics, for which the penalty was more than one year's imprisonment, could neither leave from nor enter the United States unless he registered with U.S. Customs.

  The Act also provided for surrender of all existing heroin to the federal government (actual import of opium for heroin manufacturing had been banned in 1924), irrespective of whether that heroin had been manufactured prior to 1924.

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17. *Barbiturates and Tranquilizers*

- During the 19th century, opiates had been used frequently for their sedative benefits. These were found to be addictive, and physicians often prescribed bromide salts as an alternative. Bromides never gained great popularity due to the risk of chronic bromide poisoning. Until the first years of the 20th century, physicians continued to prescribe alcohol as the most common sedative.

- 1903: Barbital, a derivative of barbituric acid, came into medical use as a tranquilizer and sedative. Trade name for the product was Veronal®. Nine years later, Luminal® (phenobarbital) came on the market.

  Demand for the new sedatives increased rapidly.

  "More than 2,500 other barbiturates were subsequently synthesized, and some 50 of them were accepted for medical use--as sedatives, as sleeping pills, and for other purposes. Long-acting barbiturates were developed for daytime sedation; short-acting barbiturates followed for prompt sedation and for inducing sleep without delay...By the end of the 1930s an estimated *billion* grains (of barbiturates) were being taken each year in the United States alone" (Brecher, 1972).

- 1942: the magazine *Hygeia* (later re-named *Today's Health*), published by the American Medical Association, published the first article warning against use of barbiturates except by those under a physician's care. That article, titled "1,250,000,000 Doses a Year," was followed by a 1945 *Hygeia* feature called "Waco was a Barbiturate Hotspot." *Collier's* followed with its April 1949 article, "Thrill Pills Can Ruin You."

  Agents of the United States Food and Drug Administration worked to cut down available supplies of non-prescription barbiturates. States passed laws. And a barbiturate black market developed.

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- One medical result of the barbiturate panic was a trend toward prescribing non-barbiturate sedatives and sleeping pills (i.e., Doriden®, Placidyl®, Noludar®, in increasing quantities.

- The "minor tranquilizers" came into popular medical use.

  The first of these was meprobamate (marketed as Miltown®), followed by chlordiazepoxide (Librium®), and diazepam (Valium®). The "minor tranquilizers," particularly, have since gained a reputation as substances of common use.

18. *Amphetamines*

- Amphetamines were first synthesized in 1887, but little use for them was found until 1927, when laboratory experiments discovered their usefulness in raising blood pressure and stimulating the central nervous system.

- During the later part of the 1930s, amphetamines were used to treat both narcolepsy and hyperactive children.

- During World War II, army physicians issued amphetamines to American, British, German, and Japanese armed forces for alleviation of battle fatigue (as cocaine had earlier been used for Bavarian soldiers).

- Following the war, physicians routinely prescribed amphetamines for depression.

- During the Korean War era, the earliest intravenous use of amphetamines by United States servicemen was reported. Soldiers stationed in Korea and Japan during the early 1950s mixed heroin with amphetamine and injected the combination. (This was a variation of the traditional "speedball," which combined heroin and cocaine.)

  A number of returning servicemen brought the custom back to the United States.

- During the late 1950s, some San Francisco area physicians prescribed amphetamine injections as treatment for heroin addiction often using Methedrine.

- As recently as 1960, it was reportedly common practice in the San Francisco area for injectable amphetamines to be sold without prescription, or via telephoned "prescriptions" by people impersonating physicians.

  The resultant scandals during 1962 and 1963 caused most injectable amphetamines to be taken off the market.

- With injectable amphetamines available legally only to hospitals, black market supplies appeared. Illicit laboratories specializing in amphetamines were reported in the San Francisco area as early as 1962.

19. *LSD-25*

- In 1938, Drs. Albert Hofmann and W. A. Stoll of Sandoz Laboratories in Basel, Switzerland, discovered the ergot derivative *d-lysergic acid diethylamide.*

- Since this was the twenty-fifth lysergic compound the scientists had discovered, they called the substance LSD-25. When initial testing on animals showed no interesting properties of the drug, the substance was put away for the next five years.

- In 1943, Dr. Hofmann took the first acid trip.

  "On April 16, 1943, Dr. Albert Hofmann...was working in his lab at Sandoz... He was working with the derivatives of ergot, a fungus that grows on grains. Sandoz had successfully marketed ergot derivative for use in obstetrics and in treating migraine headaches. Midway through Friday afternoon Hofmann decided to go home. He felt restless and dizzy. At home, 'I lay down and immediately fell into a peculiar state similar to a drunkenness, characterized by an exaggerated imagination. With my eyes closed, fantastic pictures of extraordinary plasticity and intensive color seemed to surge towards me. After about two hours this condition disappeared.'

"Hofmann went back to the lab the next week and took what he thought was a very small amount of his new chemical. He began taking notes: 'mild dizziness... inability to concentrate... uncontrollable laughter.' Because of the war there were no cars, so Hofmann got on his bicycle to ride the four miles home, probably the last time anybody has tried to ride a bicycle four miles on LSD. 'My field vision swayed before me and was distorted like the reflections in an amusement park mirror. The faces of those around me appeared as grotesque, colored masks; marked motoric unrest.' He also had 'a clear recognition of my condition, in which state I shouted half insanely or babbled incoherent words. Occasionally I felt as if I were out of my body. Sounds were transposed into visual sensations so that from each tone or noise a comparable colored picture was evoked, changing in form and color kaleidoscopically.' That was the second acid trip. Sandoz sent the new drug off to the University of Zurich and Hofmann's associate, W. A. Stoll, wrote up the results of the testing. LSD was not toxic and was not addicting but an extremely small dosage had profound results. Most drugs are measured in micrograms, or millionths of a gram. Five grains, an aspirin-sized tablet, could produce effects in 3,000 people.

"The United States Army began to stockpile LSD. Therapists around the world began to use it with patients. It allowed, they said, repressed memories to come forth, and the material that came up could be better understood because it took the form of visual symbols. Yet, with all the imagery, the patient kept a state of awareness, and retained his insights after the experience. Originally, LSD was called a hallucinogen, that is, an agent that causes hallucination. But the LSD ingester was not quite like, for example, an alcoholic with *delirium tremens* who sees snakes and green elephants. The alcoholic thinks the snakes and green elephants are real; the LSD subject 'does not ordinarily accept them as real. He remains aware that what he is experiencing is a drug-induced phenomenon.' So LSD was not a

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	hallucinogen. Dr. Humphrey Osmond, one of the first psychiatrists to use the drug, called it psychedelic, mind-manifesting, or mind-expanding...and he hoped LSD would be an aid to curing schizophrenia in his Saskatchewan hospital' (Smith, 1975). 20. *LSD Research* - For the next 20 years, LSD-25 was tested as a possible cure or treatment aide for varied medical problems. - The Maryland Psychiatric Research Center among other facilities, had success in using the drug for treating chronic alcoholics. - The Cook County Hospital in Chicago and Sinai Hospital in Baltimore reported good results when using LSD to treat pain in terminal cancer patients. - In 1950, Drs. Anthony K. Busch and Warren C. Johnson published the first report on the use of LSD in psychotherapy treatment. The doctors, after using the drug on 21 hospitalized psychotic patients, concluded that LSD-25 was a promising means for dealing with chronically withdrawn patients, and that it might serve as a method for shortening the duration of psychotherapy treatment in general. - In Poland, Dr. M. Rostafinski used the drug to treat a small group of epileptic patients. - In the United States, Dr. Charles Savage reported a particular *lack* of success in using LSD to treat 15 patients suffering from depression. - In 1954, a German physician named Federking proposed that LSD was more effective than mescaline in treating neurotic patients "refractory to psychotherapy." 21. *Legislation Controlling LSD* - Before 1962, almost all the LSD-25 and psilocybin available in the United States and Canada was produced by Switzerland's Sandoz Laboratories. They could be

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	purchased, legally, by physicians, psychiatrists, psychologists, and other mental-health professionals who could certify legitimate use for them. - The only major restriction was a United States Food and Drug Administration label on each LSD container: "Caution: New drug--limited by Federal law to investigational use." - During 1962 and the years immediately following, the Food and Drug Administration issued more stringent regulations pertaining to investigational new drugs (IND), including LSD-25. In consequence, many states passed legislation outlawing LSD and a new Federal law further restricting use of investigational drugs, including LSD, went into effect. - Sandoz virtually stopped production of LSD-25. - The formula for brewing LSD could be gotten from the U.S. Patent Office for 50 cents, and precursor chemicals were still relatively easy to acquire. Underground laboratories began LSD production. - Far from limiting seriously the availability of LSD, the new Federal regulations only served to give the drug wider publicity than it would otherwise have gotten. - "The Sixties took over, the psychedelics became a subcult, the partisans said it brought Utopia, the antagonists said it brought the plague; LSD became a terror symbol, which made it attractive to children who...knew that the Establishment and the law and their partents were all lying. 'The anti-LSD publicity, the scare campaigns, and the laws,' said *Consumer Reports*,'helped to convert what had been (for 20 years) a relatively unknown and innocuous drug into a quite damaging one.' "... The laws were passed, the police were alerted, raids began, the generation gap widened, and the epidemic spread" (Smith, 1975).

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22. *LSD and Society*

- During the summer of 1960, Dr. Timothy Leary tried the Mexican psilocybin mushroom. And liked what he found. He and Dr. Richard Alpert, a colleague at Harvard University's Center for Research in Human Personality, began experimental work with LSD and synthetic psilocybin--which, by the way, was first synthesized by Sandoz's Dr. Hofmann.

- In fall 1960, Leary and Alpert purchased some psilocybin from Sandoz for an experiment they planned with prisoners at the Massachusetts Correctional Institute in Concord. Initial results were promising, with prisoners who had taken a psilocybin trip prior to release from Concord found less likely to be returned for parole violation than those who had not had an Alpert/Leary trip.

- Drs. Leary and Alpert continued to take recreational/experimental psychedelic trips themselves.

- "You are never the same after you've had that one flash glimpse down the cellular time tunnel," Leary said. "Turn on."

- In 1962, the FDA, Massachusetts law enforcement officials, and the Harvard board of trustees began investigating Leary. Harvard's *Crimson* warned students against LSD. National media spread the alarm. While FDA and State officials were investigating him, Leary took advantage of this new celebrity stature to campaign nationally for LSD.

- At the University's request, Leary and Alpert left Harvard in Spring, 1963.

- "Post expulsion... [Alpert and Leary] landed in a 55 room mansion in Millbrook, New York, owned by a Mellon heir, Billy Hitchcock, with the local cops peering through the bushes. The local cops were led by G. Gordon Liddy, later known as a Watergate burglar...

- "... Eventually G. Gordon Liddy went to prison for burglarizing the Watergate... Leary went to prison for possessing a fingernail's worth of marihuana... and Richard Alpert went to India and became Baba Ram Dass, the very symbol of the seeker" (Smith, 1975).

- In retreating to Millbrook, Leary and Alpert had hoped to minimize their difficulties with the law. But they still had to contend with opposition groups.

- "Leary and Alpert preached 'set and setting.' Everything in taking LSD, in having a fruitful-freakout-free LSD experience, depended on set and setting. You should take it in some serene and attractive setting, a house or apartment decorated with objects of the honest sort, Turkoman tapestries, Greek goatskin rugs, Cost Plus blue jugs, soft light--not Japanese paper globe light, however, but untasselated Chinese textile shades--in short, an Uptown Bohemian country retreat of the $60,000-a-year sort, ideally... The 'set' was the set of your mind. You should prepare for the experience by meditating upon the state of your being and deciding what you hope to discover or achieve on this voyage into the self. You should also have a guide who has taken LSD himself and is familiar with the various stages of the experience and whom you know and trust" (Wolfe, 1968).

23. *LSD: Prohibition*

- 1965: Federal drug abuse control regulations were passed. Based on its power to regulate interstate commerce, Congress now regulated the sale and use of depressant, stimulant, and hallucinogenic drugs.

- The Drug Abuse Control Amendments required the registration of every person who engaged in the manufacture, preparation, compounding, wholesaling, jobbing, and distribution of depressants or stimulants. Penalties were provided for anyone who sold, gave away, or otherwise distributed any substance in violation of the law, but no stipulation was made regarding someone who possessed depressant or stimulant drugs for use by members of his own household.

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- 1968: Amendments to the legislation granted more strict penalties for anyone convicted of selling or distribution. For the first time, the 1968 amendments also provided for penalties (not more than one year in prison, a fine of not more than $1,000, or both, for a first conviction) for anyone found guilty of illegally *possessing* a depressant or stimulant drug.
- 1965: New York state passed a law providing for a maximum of two years in prison for anyone convicted of possessing, selling, giving away, or otherwise distributing LSD or "LSD-like drugs." Subsequent panic by New York residents caused penalties to be increased to a maximum of 20 years in 1966.
- 1966: California passed the Grunsky bill, which prohibited possession, sale, manufacture, or importation of LSD and DMT into the state. One notable result of the California legislation was to raise the average price of an acid trip from $3 to $10.
- Prior to 1962, the Food and Drug Administration had labelled LSD an "investigational new drug." By 1966, it was almost as well known as aspirin.
- "For twenty years, from 1943 to 1963, the dissolving boundaries and unleashed memories and flowing feelings produced by the interaction of Dr. Hofmann's chemicals and minds brought no talk of revolution. The subjects and the therapists both had short hair, and society paid them no attention... The Freudians found Freudian symbols. The Jungians found Jungian archetypes and the collective unconscious, the Rankians found separation anxiety, the Sullivanians found oral dynamism...

  "Then came: Free Speech, birth control pills, long hair, brotherly love, Flower Children, predators on the Flower Children, cops, narcotics, speed, laws, judges, politicians campaigning, busts, riots,

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	Vietnam, war resisters, the Mafia, Richard Nixon, Woodstock. Confrontation. "Psychedelics were no longer experimental substances used by researchers to peel back the layers of the mind, they were a social issue--and a divisive one at that. LSD ADDICTS STARE AT SUN, the newspapers reported; no point in detailing the hoax, newspapers print what they believe sells. Someone at the *Saturday Evening Post* must have known that picture was thalidomide babies, not 'LSD babies,' but they gave it the LSD caption; more proof that the Establishment lies, said the counter-culture. Were there some chromosome breaks in the lab experiments? Why was that front-page, said the counter culture, when the same breaks for caffeine and aspirin go unreported? Could it be because coffee and tea and aspirin are major advertisers?" (Smith, 1975). 24. *Summer, 1967* - In summer, 1967, students who heard Leary and Alpert's promises of universal love, freed consciousness, enlightenment, inner peace, and general good times and LSD all got together in San Francisco. - "Right now there are two ways it can go in Haight-Ashbury. One is the Buddhist direction, the Leary thing. There are good heads like Michael Bowen and Gary Goldhill, who want to start the League for Spiritual Discovery here and pull the whole movement together into one church and give it a focus and even legal respectability. And they have given up much for this dream. Goldhill is a beautiful head! He is an Englishman who was writing this experimental stuff for TV in England and the BBC sent him to the U.S....and he took a vacation in Mexico and ran into some American heads in San Miguel de Allende who said, Man, you got to come back here when the rainy season starts and take some magic mushrooms, and damned if they didn't send him a telegram in Guadalajara or wherever--RAINS CAME MUSHROOMS UP

--and he returned out of curiosity and took the mushrooms, just as Leary had, and discovered the Management and gave up all, all the TV BBC game and dedicated himself to The Life...for, as Leary has said, a home should be a place of purity that the Gautama Buddha himself could walk into from 485 B.C. and feel at home. For some day grass must grow again in the streets, in pastoral purity, for life is shit, a duress of bad karmas, endless fight against catastrophe, which is to be warded off finally only by utter purification of the soul, utter passivity in which one becomes *nothing*... but a vessel of the *All*...the All-one...

"...as against the Kesey direction, which has become the prevailing life style of Haight-Ashbury...*beyond catastrophe*...like, picking up on anything that works and moves, every hot wire, every tube, ray, volt, decibel, beam, floodlight and combustion of American flag-flying neon Day-Glo America and winding it up to some mystical extreme carrying to the western-most edge of experience" (Wolfe, 1968).

- "The Haight-Ashbury heads held the first big 'be-in,' the Love Festival on October 7, on the occasion of the California law against LSD going into effect. Thousands of heads piled in, in high costume, ringing bells, chanting, dancing ecstatically, blowing their minds one way and another and making their favorite satiric gesture to the cops, handing them flowers, burying the bastids in tender fruity petals of love ...the thing was fantastic, a freaking mind-blower, thousands of high-loving heads out there messing up the minds of the cops and everybody else in a fiesta of love and euphoria" (Wolfe, 1968).

- Orange Sunshine, a combination of lysergic acid and ergotamine tartrate, was reportedly Owsley's best product. To the buyer on the street, just the word "Sunshine" was enough to ensure quality in LSD.

- Soon, due to Federal restrictions and penalties, chemically-pure LSD-25 was no longer available. Owsley and his chemists kept trying to improve their product, but Sandoz they were not. Searching for the ultimate "acid," they mixed Orange Sunshine with strychnine, amphetamines, other chemicals. They called them Clear-Lite, Window Pane, Purple Pie, Yellow Smash, but with no FDA to control production, "acid" wasn't only LSD-25 any longer.

- The flower children were uncritical consumers. They believed in trust, and they often trusted people who shouldn't have been.

- "Mescaline" was rarely pure, or even partially composed of, mescaline.

- "Psilocybin" was sometimes the dried magic mushroom, sometimes its synthetic equivalent, sometimes canned grocery store mushrooms soaked in phencyclidine (PCP), an animal tranquilizer producing a chemical reaction close to alcohol intoxication.

- Amphetamines weren't pure. Most every substance was cut with strychnine or arsenic--or even rat poison or baby powder. Even the cannabis was often treated with something to make it "better" than nature intended.

- "When the children took the strychnine, or the arsenic, or the atropine, or the Methedrine, or even LSD--sometimes there really was a college chemist just cooking for his friends--they sometimes had adverse reactions, whereupon their friends dumped them into the emergency room of a hospital, an environment that can produce a bad trip in people who are stone cold sober and just passing through" (Smith, 1975).

25. *Legacy of the Summer*

Before long the summer of love was corrupted. Police started raiding the children's homes and carting them off to jail on charges ranging from illegal possession of drugs to cohabitation.

- Chemicals bought on the street were increasingly unreliable.
- "Speed freaks" and "junkies" moved in, bringing their amphetamines and heroin with them. The flower people moved to the country: the heroin and amphetamine users stayed.
- As early as 1965, the underground press had tried to warn users of cannabis and LSD away from amphetamines. Poet Allen Ginsberg said it best, in his December 1965 interview in the Los Angeles *Free Press*:

  "Let's issue a general declaration to all the underground community, *contra speedamos ex cathedra*. Speed is antisocial, paranoid making, it's a drag, bad for your body, bad for your mind, generally speaking, in the long run uncreative and it's a plague on the whole dope industry. All the nice gentle dope fiends are getting screwed up by the real horror monster Frankenstein speed freaks who are going around stealing and bad mouthing everybody."

- Meanwhile, the national media continue their campaign against LSD and marihuana. As they had in the past, all that governmental threats and prohibitionist scare tactics accomplished was to advertise the availability of chemicals.
- The 1970 *Interim Report* of Canada's (Le Dain) Commission of Inquiry into the Non-Medical Use of Drugs discussed this phenomenon:

  "Some 'speed' users who inject almost suicidal doses of methamphetamine into their veins without regard for their safety and health, may actually be trying to test the truth of the youth slogan, 'Speed Kills.' The role of the doomed person who is at once a martyr sacrificing himself, a hero braving the confrontation with certain destruction and a gambler playing dice with death, is a role which seems to have a strong seductive pull for some young people who are morbidly hungry for compassion, admiration and excitement. For these individuals the slogan 'Speed Kills,' may, paradoxically, carry more attractive than deterrent power--and thus may not serve the purpose for which it is being promoted."

- Government efforts to curb increasing black market amphetamine traffic continued. Underground speed labs were busted. Legal stimulants were controlled closely. Prices went up. Black market merchants began importing increased amounts of cocaine to meet the stimulant demand.

26. *Heroin and the Middle Class*

- The descendents of Haight-Ashbury turned increasingly to heroin. Use was no longer centered mainly in the non-white ghettos; the heroin habit was finding a place in the lives of children from white, middle income homes.

- In an article in the Spring, 1971, issue of the *Journal of Psychedelic Drugs*, three medical staff members of the Haight-Ashbury Free Medical Clinic traced the changing patterns of heroin use:

"Within the last two years [1969 to 1971] there has evolved a new style of heroin addict consisting largely of alienated white youth suffering from disillusionment, disaffiliation, frustration, and despair.

"1970 is becoming recognized as the 'year of the middle class junkie,' a reflection of the changing socio-economic background of today's heroin extraction. They have begun using heroin (the perfect tranquilizer) only within the last few years and are now beginning to seek medical help in rapidly increasing numbers.

"The 'middle class junkie' is...composed of two rather distinct types: the 'New Junkie' (who began using heroin after January, 1967) and the 'Transition Junkie' (who began using heroin between January, 1964 and January, 1967). The TJ is characterized by a similar family and social background to the 'New

Junkie' and differs mainly in the effects of the social atmosphere of the drug subculture that existed when he came onto the scene. He passed through a peroid of optimism and hope, and reflects this in the drugs he used heavily prior to heroin (the psychedelics and amphetamines). He is a self-medicator and a drug experimenter; he has 'tried all drugs.'

"The newer addict entered the drug subculture at a time of beginning frustration and despair, and therefore, engaged in less experimentation before 'settling' on heroin. He is more aware of some of the dangers of the 'street' drugs (having seen the effects on the Transition Junkie's contemporaries), and less of a self-treater than is Transition Junkie counterpart.

"These two groups together (NJ and TH) make up the 'middle class junkies' and are distinguished from the older ghetto-bred addicts ...by many factors other than background, family status, percentage of females, and race. They are also separated by therapeutic response, with the older addict being a more 'faithful' patient and less likely...to get 'clean' than his newer counterparts" (Sheppard et al., 1972).

- The Haight-Ashbury Free Medical Clinic study on which the above report was based uses January, 1964, as the approximate time when heroin use began to spread from non-white ghetto areas into segments of America's white, middle class community. As Sheppard, Gay, and Smith stipulate in the article, the San Francisco area has proven to be a place where drug use trends begin some six to 18 months before they are evident in the rest of the country.

27. *An Addicted Author: Heroin and Hallucinogens*

- Author William Burroughs wrote the following about his own experience with heroin:

"When I speak of drug addiction I do not refer to keif, marihuana, or any preparation of hashish, mescaline, Bannisteria Caápi, LSD6, Sacred Mushrooms or other drug of the hallucinogen group... There is no evidence that the use of any hallucinogen results in physical dependence. The action of these drugs is physiologically opposite to the action of junk. A lamentable confusion between the two classes of drugs has arisen owing to the zeal of the U.S. and other narcotic departments...

"... All the hallucinogen drugs are considered sacred by those who use them--there are peyote cults and Bannisteria cults, hashish cults and mushroom cults--"The Sacred Mushrooms of Mexico enable a man to see God"--but no one ever suggested that junk is sacred. There are no opium cults. Opium is profane...

"Junk is the ideal product...the ultimate merchandise. No sales talk necessary. The client will crawl through a sewer and beg to buy... The junk merchant does not sell his product to the consumer, he sells the consumer to his product. He degrades and simplifies the client...

"I awoke from The Sickness at the age of forty-five, calm and sane, and in reasonably good health except for a weakened liver and the look of borrowed flesh common to all who survive The Sickness... Most survivors do not remember the delirium in detail. I apparently took detailed notes on sickness and delirium. I have no precise memory of writing the notes which have now been published under the title *Naked Lunch*...

"... I lived in one room in the native quarter of Tangier. I had not taken a bath in a year nor changed my clothes or removed them except to stick a needle in the fibrous grey wooden flesh of terminal addiction. I never cleaned or dusted the room. Empty ampule boxes and garbage piled to the ceiling. Light and water long since turned off for nonpayment. I did absolutely nothing. I could look at the end of my shoe for eight hours. I was only roused to action when the hourglass of junk ran out...And suddenly my habit began to jump and jump. Forty,

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sixty grains a day. And still it was not enough. And I could not pay" (Burroughs, 1960).

28. *Federal Response to Heroin Use*

- 1966: the Federal government passed the Narcotic Addiction Rehabilitation Act, which provided treatment and rehabilitation for both convicted and volunteer heroin addicts. The Act specified conditions for short-term, in-patient care in medical facilities, and for long-term, continued out-patient care in the community. The United States Surgeon General was mandated to assist states and municipalities in developing treatment programs and facilities for addicts.

- As defined in the law, "treatment" was to include "confinement and treatment in an institution, and supervised after-care in the community...designed to protect the public and benefit the addict by correcting his anti-social tendencies and *ending* his dependence on addictive drugs and his susceptibility to addiction."

- In 1968 the Department of Justice's Bureau of Narcotics and Dangerous Drugs was established. The Bureau, charged with enforcing federal laws with the goal of suppressing illegal drug traffic, replaced the two agencies previously concerned with drug-related activities: the Treasury's Federal Bureau of Narcotics and HEW's Bureau of Drug Abuse Control.

29. *Heroin: The Vietnam War*

- Vietnam brought many middle class youngsters who would otherwise never have known about the drug into contact with heroin.

- Like Korean War soldiers, many United States soldiers in Vietnam had some extent of heroin habit. Some were heroin users before going to Vietnam; others became users not long after arriving.

- "Shortly after the United States began military support to South Vietnam, high incidence of drug abuse, particularly marihuana and

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	dangerous drugs such as the amphetamines and barbiturates occurred among the military stationed there." The Department of Defense appointed several Task Forces to inquire into...the problem... Early reports from one of the Task Forces stated that there was a relatively low rate of drug abuse in the services... The report concluded that there was virtually no drug addiction in the military... "In contrast...in 1969 the military conducted about 36,000 investigations of drug abuse and in 1970, about twice that many" (Levine, 1974). - "One survey by two army physicians conducted on GI's returning from Vietnam showed that more than 16 percent admitted using heroin during their final thirty days in Vietnam. But about six percent of those GI's interviewed admitted using heroin before going to Vietnam. A congressional Committee in early 1971, found that a significant portion of the drug users were inducted into the services because of inadequate pre-induction screening. "During early 1971, as a result of an amnesty program, the Pentagon reported that nearly 16,000 servicemen voluntarily identified themselves as heroin users and sought treatment. The majority of those servicemen who sought treatment (14,736) were from the Army. The remainder (977) included servicemen from the Navy, Marines, and Air Force. There is no estimate of how many servicemen qualified for treatment but did not identify themselves as heroin users. "...Whatever estimated figure one chooses to accept, there were anywhere from 25,000 to 50,000 American troops in Vietnam who were heroin users by mid-1971, and this estimate does not include addicted servicemen who had previously served in Vietnam and returned to civilian life. Perhaps the most alarming statistics show that the death toll from heroin overdose [rose] in Vietnam despite the reduction in the number of men stationed

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there. In 1970, the *quarterly* average reported was 26 deaths from heroin overdose; in the first quarter of 1971, the figure rose to 35 deaths" (Levine, 1974).

- In early 1971, the Veterans Administration set up a treatment program for discharged addicts. By June 1971, 32 clinics treating 6,000 heroin addicts were in operation. Treatment was primarily by methadone maintenance.
- In June, 1971, President Richard Nixon appointed Dr. Jerome H. Jaffe to head the new White House Special Action Office of Drug Abuse Prevention, which was to have overall responsibility for major federal drug abuse prevention, education, treatment, rehabilitation, training, and research programs.
- The only area that Dr. Jaffe's office did not oversee was the Federal Bureau of Narcotics and Dangerous Drugs, under control of the State Department and the Department of Defense.

30. *Comprehensive Federal Legislation*

In 1970, the Federal government passed the Controlled Substances Act which, for the first time, provided a comprehensive, integrated set of regulations regarding substance ("drug") use and control.

- The major areas covered by the Act are:
  - Five separate substance schedules are created, according to the supposed potential for abuse and the currently accepted medical uses for the drugs in each substance group.
  - The five groups are:
    - Schedule I: heroin; marihuana; LSD; THC; hallucinogens.
    - Schedule II: opium; morphine; Dilaudid; Demerol; Methadone; cocaine; liquid amphetamine.

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    - Schedule III: amphetamines; Nalline; short-acting barbiturates; and Doriden, Noludar, Ritalin, paregoric.
    - Schedule IV: minor tranquilizers; long-acting barbiturates.
    - Schedule V: substances that can be sold over-the-counter, without prescriptions; primarily, cough syrups, such as terpin hydrate with codeine.
  - Different penalty scales are provided for law violations within each substance schedule.
  - The Act differentiates between "addict," "user," and "trafficker" when setting penalties.
  - Various legal jurisdictions for controlling drugs as they pass from manufacturer to distributor to consumer are specified.
  - Provision is made for including any new substances or drugs under the five schedules of the existing Act.
  - The Act calls for increased research in the field of drug abuse prevention, and for continued research on treatment and rehabilitation methods.
- Also in 1970, the National Conference of Commissioners adopted a Uniform Controlled Substances Act, but provisions outlined in the act were to be adopted separately by each state. Like the Federal Controlled Substances Act of 1970, this was an attempt to create a codified system of drug control, classifying all narcotics, the dangerous drugs, and marihuana into five separate schedules, with their separate criteria and separate penalty ranges. Particular penalties were left to the determination of individual States.

31. *Transitions: 1970 to 1977*

- Drug use in recent years has meant neither the social stigmas nor the revolutionary political convictions that were partners of the drug culture in the 1960s.

- *One of the most significant patterns to emerge during the 1970s is that there are no set stereotypes of drug users and drug use patterns anymore. Ghetto junkies aren't the only heroin addicts. Student radicals aren't the only people smoking marihuana and trying cocaine.*

- At one time in the 20th century, the statement "minorities are the heroin addicts" might have been largely true. Use of opiates once implied a collection of alien, ghetto-based imagery.

  Vietnam challenged the preconceptions. The country saw a significant percentage of its white, middle class young people return from the Vietnam War with the heroin habit. For the first time, the junkie stereotype wasn't adequate to describe the problem.

  Use of marihuana, LSD, cocaine, mescaline during the 1960s often implied the user's belief in social revolution and his search for the cosmic knowledge Leary had promised. When Vietnam, Kent State, the marches on the Pentagon were over, the student radicals and the seekers began to disappear. They became professionals, parents, members of the community. To some extent, most still used some of the drugs they had been turned on to during the decade before. Younger students kept their elders' patterns of drug use--but without the implicit social/revolutionary convictions.

32. *The Polydrug Phenomenon*

- The New York *Times* in a March 25, 1973, article titled "Mixing of Mind-Altering Drugs Rises as Spread of Heroin Addiction Slows," attempted to analyze what has been called *polydrug use:*

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	- "Allowing for variations of region, age and class, cocaine, methadone and alcohol, and a variety of barbiturates and other 'downers' --most notably a sedative-hypnotic known as methaqualone--appear to be increasingly popular street drugs. "And, while it is difficult to gauge the extent of the phenomenon, a considerable number of people appear to be casually using and abusing several drugs in often dangerous combinations--methaqualone and alcohol, or methadone and alcohol... "In San Francisco, a narcotics police officer notes: 'Three years ago [1970] it was common to have five or six young people collapse in school every day from an overdose of barbiturates. We don't get that anymore; the kids are becoming more sophisticated about drugs.' "As for heroin, a Chicago drug counselor observes: 'Word has gone out to the black community that smack is part of their oppression, and they are sticking to grass and psychedelics and pills, uppers and downers, for their highs.' "Polydrug abuse, as the drug-mixing phenomenon is known, appears to be characteristic of both school-age dabblers and old-time junkies, who are finding it almost impossible to 'cop' (buy) good-quality heroin. - In the September, 1977, issue of *Esquire* magazine, a Yale University class of 1975 graduate talks about drug use when he was on campus. It was, he says, a time of many drugs and few politics. - "The trappings of rebellion hung loosely on us, like older siblings' clothes. We espoused hand-me-down politics and tripped on hand-me-down LSD... "We saw the drop outs of older classes crawling off to communes or hanging about the college... They were exhausted--refugees from themselves--politically, culturally and physically beat. A conveyor belt of new drugs, each with its own ideology and

method, had carried them from Dylan to Trotsky to Baba Ram Dass...

"Looking back it is hard to overstate the importance of drugs. There was mescaline, Methedrine, Quaaludes, scopolamine, LSD, MDA, THC, barbiturates and Dex. Every dormitory had a well-thumbed copy of the *Physician's Desk Reference*; a remarkable number of students could talk at length about Ritalin contraindications. They were the same drugs that our elders had taken, but we took them without the same conviction--the goal had shifted from revelation to entertainment.

"The effect of some of these drugs was not unlike drinking: Quaaludes were for evenings of bumping into tables and warm, cuddly sex. Speed of the garden variety, like Dexedrine, was strictly functional: something for exam time. Methedrine, the speed that killed, had the shortest fuse you could find. THC was a marihuana extract, MDA was a mid-range pseudo-psychedelic, and nobody ever found out what the hell STP was. Mescaline was the war-horse hallucinogen; it was usually high quality, and you could take a good bit of it with no lasting effect. Acid was another story. Where mescaline just set you up for a good time, acid tore down the wall between you and what you were looking at. People who took a great deal of it are still wandering around saying things like 'I don't need to use the telephone--they can hear me.' One of my older friends, a South African poet, practically lived on the stuff. He published a volume of poetry about 'helium-flowers' and 'original spin,' his eyes began to bulge, and he went back to Africa.

"Drugs were for fun. On Passover some Jewish students would get together and smoke scopolamine, then go over to the dining hall and play poker with the matzos. Once I awoke at four a.m. and heard a strange murmuring. I looked out my window, and there, in the moonlight, was my freshman counselor, deep in conversation with a pigeon. The same freshman counselor, an ace law student, once made the mistake of recruiting half of the students in his entryway as a moot-court jury. The jury prepared for the trial by dropping mescaline: when a verdict was requested, the law professors who filled the auditorium heard twelve happy men pronounce the judge, a prominent D.A., guilty of bribery" (Isemand, 1977).

- For marihuana, the 1970s represent a growing societal inclination toward tolerating use of the substance. While cannabis use is not legal per se, use has become so widespread that several municipalities and one state (Alaska) now impose no penalties for marihuana possession.
- In its 1972 report *Marihuana: A Signal of Misunderstanding*, the National Commission on Marihuana and Drug Abuse summarized contemporary conflicting opinions regarding possible revisions to federal marihuana policies:
- "Marihuana's advocates contend that it is no more or less harmful than alcohol and tobacco and should therefore be treated in similar fashion. The drug's adversaries contend that it is a stepping-stone to the narcotics and should remain prohibited. At the present time public opinion tends to consider marihuana less harmful than the opiates and cocaine and more harmful than alcohol and tobacco.

  "Interestingly, while marihuana is perceived as less harmful than before, alcohol and tobacco are regarded as more harmful than before. In some ways, the duality which previously characterized American drug policy has not been supplanted by an enlightened skepticism as to the variety of approaches to the non-medical use of various drugs.

  "Despite this shift in attitudes, however, the use of alcohol and tobacco is not considered a major social problem by many Americans, while marihuana use is still so perceived."
- By August, 1977, prevalent opinion had altered enough so that President Carter could propose Congress's passing legislation to

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	"de-criminalize" penalties for marihuana possession. - The August 15 issue of *Time* magazine, in an article titled "Carter's Grass-Roots Appeal: Can 35 million Americans be wrong about pot?" describes the current status of marihuana in the Federal system. - "'Penalties against the possession of a drug should not be more damaging to an individual than the use of the drug itself.' So said Jimmy Carter in urging Congress last week to reduce federal penalties for possession of up to one ounce of marihuana, enough for about four dozen joints. For a first offense, the maximum penalty now is a year in jail, and a $5,000 fine for possession of any amount of pot. "The President's appeal stirred little enthusiasm on Capitol Hill, though an estimated 35 million Americans, including Carter's three sons, have smoked pot on occasion. Liberals hope that his message will enable them to get a hearing next year on a bill that would lower the penalty to a $100 fine. The legislation has been stuck in committee for five years. Chief reason: polls show that most Americans still believe that pot is addictive, harms users physically and usually leads them to hard drugs. "None of this has been proved in more than ten years of scientific studies. Early research raised fears that even occasional puffing on a joint might lead to personality changes, birth defects, brain shrinkage, sterility in men, lowered resistance to disease and heart damage. Other studies have disputed these findings. Moreover, several studies have indicated that the major active ingredient in pot, tetrahydrocannabinol (THC), might even have medical uses. THC expands bronchial passages, which helps asthma patients breathe easier. It decreases pressure inside the eyes, which alleviates glaucoma. It also controls vomiting, relieves depression and, in some cases, eases pain.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	"Although a final verdict must await further studies, most researchers now believe that aside from rare bad trips by novice smokers, marihuana is hazardous only for chronic heavy users--people who get stoned nearly every day. They risk becoming psychologically dependent on pot and damaging their lungs with the tar in marihuana smoke. But light or occasional use of marihuana--once or twice a week--usually produces only a pleasant high, no more dangerous than mild intoxication from alcohol. Of course, pot like alcohol affects users' judgment and reflexes, so it can lead to accidents if people drive or operate machinery while high. "Alaska has no penalties at all for possession of small amounts. Nine other states (California, Colorado, Maine, Minnesota, Mississippi, New York, North Carolina, Ohio, and Oregon) have reduced the penalties; 34 more may follow suit. Entrepreneurs would like to cash in on the growing demand for pot. Louisville Promoter Gatewood Balbraith has organized a grass-roots campaign to put Kentucky in position to corner the market if and when pot is legalized. Says he: 'Kentucky's already got pari-mutuel betting. It's got whiskey and it's got tobacco. You just can't beat the combination of marihuana and money.' Under his plan, the state would license growers and retail dealers. He calculates that the scheme would cut in half the street price of pot (now about $25 per ounce in Louisville) and earn Kentucky about $150 million a year in fees--a heady prospect for politicians who would like a painless way to cut taxes and raise revenues at the same time."
10 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.
5 minutes	SUMMARY ● State the following:

- As we look at the social-historical development of substance use in this country, one can readily see that drugs have been used for pain-killing, social-recreational, and intensifying functions. It is evident that there have been legal responses to substance use in this country. However, rarely have laws been so widely disrespected and broken as the current criminal laws against drug possession and sales. When a person uses an illegal drug, he faces not only the effects of the drug but also the consequences of society's designation of him as a criminal.

- It is hard to separate the effects of the drug laws from simultaneous factors like personal and lifestyle changes or drug effects. However, there are perspectives and indications that can be drawn from the history that represent consequences of the drug laws on a certain group, more than they represent the effects of the drugs themselves or characteristics of the groups which take them.

- The perspective is as follows:

    1. An impulsive or personal decision to try the drug, with the law's having little effect on it.
    2. A social group uses drugs, and develops a rationalization for its illicit activity, as well as a shared conception of itself as an "outlaw culture."
    3. The group builds a shared theory of political dissent, and connects their theory to other events and information.
    4. The individuals develop a heightened sensitivity to civil liberties arguments for drug use, and feel controlled unjustly by the drug laws, as they seek to withdraw into their own private pursuits.
    5. They end up with a more tolerant perspective on drug laws and an understanding of cultural contradictions and the

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	relativity of social norms. - Before long, the generation now in its teens and twenties will be in its thirties and forties. Judges, prosecutors, and even narcotic agents, along with legislators and teachers, will be drawn from the pot smoking, coke-sniffing, pill-popping generation. When that time comes, they will find themselves confronting the same basic drug issues their elders confront today. - How can the damage done by alcohol, nicotine and other drugs be minimized? How can young children be protected from drug excesses? How can adolescents be helped to exercise prudence? How can nonchemical alternatives to the drug experience be developed and popularized? How can human life be enriched? - We hope that when the next generation takes over, they will use history as a guide to how mankind has used and misused drugs in the past, and as a warning against repeating the errors society is making today.
	● Divide the large group into small groups of 8-12 participants. ● Assign a small group meeting space.
30-45 minutes	SMALL GROUP DISCUSSION ● State the following: - The trainer presentation outlined the social-historical development of substance use, stressing the painkilling, social-recreational and intensifying functions of substance use. Emphasis was also given to the changes in social and legal responses to substance use that parallel these developments. This group discussion should focus on feelings and reactions to the presentation. ● Allow participants the opportunities to discuss the presentation and its effect on them.

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	● Use these additional questions if participants are not involved in the discussion: - What role (function) do substances (drugs) play for you? (painkilling, social-recreational, intensifying) - Under what circumstances do you use substances (drugs)? - What patterns of use are you aware of? ● Allow a 30 minute discussion. END OF MODULE

INFLUENCE EXERCISE: THE GUARANTEED RESPONSE

For each of the products or substances listed below, give several key words or phrases you would use to elicit the guaranteed response you desire from your constituency.

Feel free to use trite phrases, hackneyed words. They have been used before--probably because they are effective in evoking a predictable response. Remember, you are more knowledgeable than the public you seek to influence. You can give or withhold information, as you choose. Your goal is not honesty. You are not trying to teach or inform. Your only aim is to influence opinion and behavior.

1. You are seeking to increase popularity of your product through advertising. Recently, sales have begun to decline, due to questions regarding your product's effect on the health and physical well being of the user. If sales continue to decline, your company will go out of business, and 2,000 people will lose their jobs.

   Remembering those constraints, what key words and phrases would you use to promote ...

   a. tobacco

   b. foods preserved with nitrites

   c. cocaine

   d. amphetamines

e. gin ______________________

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f. LSD ______________________

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2. You are a member of a consumer-protection or other group, seeking to have production, distribution, and use of a product stopped. Your basis for action can be religious, ethical, based on scientific research, based on physicians' experience, based on personal experience that proved the product/substance harmful. You do not consider yourself a religious fanatic or a health food freak. You believe it is your obligation to help protect fellow humans from the adverse effect of that which you seek to outlaw.

With those constraints, what words and phrases would you use to sway society to support your cause, and the government to pass appropriate protective measures regarding use of ...

a. tobacco ______________________

____

____

____

____

b. foods preserved with nitrites ______________________

c. cocaine ____________________

d. amphetamines ____________________

e. gin ____________________

f. LSD ____________________

3. You are a government agency seeking to prevent or restrict use of a substance or product. The substance can be procured, legally, under certain conditions; however, there is a substantial black market source of supply, so actual procurement control is not a viable option. While you have the strength of substance control laws on your side, those laws often are not enforced, or are enforced with varying frequency and conviction. Again, the courts often provide you little assistance, as they tend to hand out relatively minor penalties to those who break the law.

   You have extensive research reports at your disposal. According to your discretion, information can be released, withheld, or conveyed in such a manner as to mean something other than what the reports actually say. In all conscience, your agency feels that people must be prevented from using the product or substance which you know can harm them.

   Under those conditions, how do you cause people to curtail use of ...

   a. tobacco ______________________

   ____

   ____

   ____

   ____

   b. foods preserved with nitrites ______________________

   ____

   ____

   ____

   ____

c. cocaine

d. amphetamines

e. gin

f. LSD

REFERENCES

Casey, Elaine. "A History of Drug Use and Drug Users in the United States." NDAC, 1977. Unpublished.

Jaffe, Dennis T. "Drug Laws: Perceptions of Illegal Drug Users." *Drug Forum*, Summer, 1974, *3*(4), 321-329.

MODULE V

SUBSTANCE ACTIONS AND POTENTIAL HAZARDS

MODULE V: SUBSTANCE ACTIONS AND POTENTIAL HAZARDS

PERSPECTIVE

The purpose of this module is to provide an accurate description of those psychoactive drugs with a potential for abuse, and to place their relative hazards in perspective. The module begins with definitions of certain terms related to drugs and drug dependence or drug-induced behavior.

This module includes:

- Overview of Module V (5 minutes)
- Lecture/Discussion: Definition of Terms (20 minutes)
- Lecture/Discussion: Narcotic Analgesics (20 minutes)
- Lecture/Discussion: General Depressants (20 minutes)
- Lecture/Discussion: Stimulants of the CNS (20 minutes)
- Lecture/Discussion: Psychedelics (Hallucinogens) (20 minutes)
- Lecture/Discussion: Cannabis Sativa (Marihuana) (20 minutes)
- Lecture/Discussion: Relative Hazards (30 minutes)
- Programmed Instruction: *What Will Happen If.....* (85 minutes)
- Summary of Module V (5 minutes)

TOTAL TIME: 4 hours

OBJECTIVES

Using the information presented in Module V as criteria, at the end of this module, and without the aid of notes, participants will be able to:

1. Identify the term "tolerance".

2. Identify the term "physical dependence".
3. Identify the term "psychological dependence".
4. Identify the term "potentiation".
5. Identify the term "cross tolerance".
6. Identify the term "placebo effect".
7. Classify substances according to the basic categories: opiates, depressants, stimulants, hallucinogens, cannabis.
8. Rank the intrinsic hazard potential to a person of at least seven substances.

MATERIALS REQUIRED

- "Definitions" written on newsprint
- "Narcotic Analgesics" written on newsprint
- "Narcotic Effects and Syndromes" written on newsprint
- "General Depressants" written on newsprint
- "General Depressant Effects and Syndromes" written on newsprint
- "CNS Stimulants" written on newsprint
- "CNS Stimulant Effects and Syndromes" written on newsprint
- "Hallucinogens" written on newsprint
- "Hallucinogen Effects and Syndromes" written on newsprint
- "Cannabis" written on newsprint
- "Cannabis Effects and Syndromes" written on newsprint
- "Criteria for Hazard Potential" written on newsprint
- "Rating of Intrinsic Hazard Potential to the Individual" written on newsprint
- *What Will Happen If.....* (A programmed instruction)

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5 minutes	OVERVIEW: MODULE V
	- Review the objectives of Module V with the whole group.
	- Explain the sequential flow of the module, highlighting:
	  - Large group introduction to the content
	  - Small group activities
	  - Lecture presentation by the trainer
	  - Individual Learning Program (ILP)
	NOTE: Be sure that you have written the definitions on newsprint prior to the following lecturette.
	- Introduce the module as follows:
	  - Either through ignorance or intent, official and unofficial information about psychoactive drugs is too often inaccurate, slanted, or frightening rather than factual. Even the scientific terms used to describe drug use have been given such emotional and symbolic connotations that they can be used as weapons. A clarification of the terms used is needed, beginning with a straight-forward, culture-free definition of the words "drug use" and "drug abuse." The purpose of this module is to provide an accurate description of the various psychoactive drugs with a potential for abuse, and to place their relative hazards in perspective.

15 minutes	LECTURE: DEFINITIONS OF TERMS - State the following: - In the previous modules we defined some terms related to substances. In order to understand fully the actions and potential hazards of some substances, we must have operational definitions. The operational definitions are as follows:

DEFINITIONS

SUBSTANCE/DRUG	Any chemical that modifies the function of living tissues, resulting in physiologic or behavioral change.
SUBSTANCE/DRUG USE	Where the desired effects of a drug can be realized with minimal hazard, whether or not used therapeutically, legally, or as prescribed by a physician.
SUBSTANCE/DRUG ABUSE	Where drugs are taken or administered under circumstances and at doses that increase significantly their hazard potential, whether or not used therapeutically, legally, or as prescribed by a physician.
DRUG DEPENDENCE	The term "drug dependence" has two distinct and independent components: psychological and physical dependence.

- *Psychological Dependence (psychic dependence; psychic craving; compulsive abuse)*

  A condition characterized by an emotional or mental drive to continue taking a drug whose effects the user feels are necessary to maintain his sense of optimal well-being.

  Psychological dependence varies with the individual and with the drug taken, and thus represents a complex interaction of personality factors and specific drug effects. When the desire to continue taking the drug becomes a "psychic craving" or "compulsion," the user may become preoccupied with drug-taking and drug-procurement. Such behavior is termed *drug-seeking behavior* or *compulsive drug use.* A further distinction could be made between:

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1. *Mere Gratification Dependence:* Where either disturbing withdrawal symptoms or treatment after abstinence would be absent or minor.

2. *Emotional Need Dependence:* Where both treatment problems and disturbing withdrawal symptoms of emotional origin upon abstinence could be major.

- *Physical Dependence*

Dependence of the body tissues on the continued presence of a drug (even in the absence of psychological dependence revealed by disturbing or life-threatening withdrawal symptoms that develop when use of the drug is discontinued.

1. Its presence is unknown as long as the drug continues to be taken; its presence is of no known medical or social consequence until the drug is withdrawn or no longer available.

2. The magnitude of physical dependence and the severity of withdrawal varies directly with the amount, frequency, and duration of drug use.

- Physical dependence manifests itself as intense physiological disturbances called the *withdrawal* or *abstinence syndrome;* the specific symptoms and signs of a psychic and physical nature which make up the abstinence syndrome are characteristic for each drug type.

The degree of physical dependence can be measured only by the severity of the withdrawal symptoms. For drugs like alcohol, the barbiturates, and the narcotic analgesics, the withdrawal syndromes are so unpleasant and threatening that they are important factors motivating the user's drug-seeking behavior and continued drug administratio to prevent their appearance.

- The development of psychological dependence is the *common denominator* in the abusive use of drugs that produce effects on the central nervous system. With certain types of drugs, such as cocaine and marihuana, psychologic

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dependence may be the only factor involved in their abuse.

Thus, psychic dependence can and does develop to some drugs that do not induce physical dependence and that, therefore, do not give rise to an abstinence syndrome after discontinuance of drug use.

- Physical dependence can also be induced by certain drugs (and under some circumstances) without any evidence of psychological dependence. For example, physical dependence can be developed to nalorphine, a drug which antagonizes the actions of morphine. The dependence manifests itself as a withdrawal syndrome when administration is abruptly stopped. However, no psychological dependence develops to nalorphine, and it is not a drug that is abused.

- Physical dependence also develops in patients receiving therapeutic doses of morphine or other narcotic agents for a period of several weeks. But the vast majority of these patients evince no desire to continue using the drug after the condition for which it was prescribed has been relieved--they develop no psychological dependence. Hence, while psychological dependence is the feature common to all drug abuse, and may be the only factor involved in the abusive or compulsive use of some drugs, physical dependence alone does not lead to drug abuse. But physical dependence frequently accompanies the psychic depence induced by drugs such as alcohol, barbiturates, and the opioids. Moreover, physical dependence occurring together with psychologic dependence is a powerful factor in reinforcing the compulsion to continue taking the drug.

- The fact that some individuals do not develop psychological dependence to drugs that can induce this phenomenon in other subjects points to the presence of a predisposing factor in the person and not in the drug...

- Many of the drugs that induce dependence also have the capacity to produce *tolerance*.

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DEFINITIONS

Drug Tolerance

Development of body or tissue resistance to the effects of a drug, so that larger doses are required to reproduce the original effect.

1. Unlike physical dependence, its presence is discerned only when taking the drug.

2. Where drug tolerance develops rapidly and almost completely, one is forced to discontinue drug taking after four or five days, until the tissues regain their prior responsiveness to it (it prevents continuous daily abuse).

3. Where drug tolerance develops slowly and the drug also produces physical dependence (e.g., heroin or alcohol), the increased dose requirement accelerates and intensifies the development of physical dependence (one gets "hooked") as well as the monetary cost.

Cross-Tolerance

Cross-tolerance refers to tolerance between different drugs, either in the same class or across drug classes. For example, tolerance to barbiturates also produces tolerance to alcohol.

- State the following:

  - Tolerance and drug dependence are separate phenomena and may develop independently of each other. Tolerance may be produced by many agents that have little or no potential for abusive use. On the other hand, drug abuse and drug dependence may occur in the absence of the development of any demonstrable tolerance. Moreover, tolerance developed to drugs that are subject to abuse is not necessarily accompanied by physical dependence. The abusive use of lysergic acid diethylamide (LSD) is an example: marked tolerance develops to LSD, but withdrawal symptoms are not seen upon abrupt discontinuance of drug use. However, tolerance is almost invariably associated

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to some degree with the use of agents that do induce physical dependence.

- Since the characteristics of the state of drug dependence are not the same for different drugs or groups of drugs, the nature of the dependence can be delineated only in terms of the agent(s) involved.

- For example, the dependent state may be designated as drug dependence of the barbiturate type, of the morphine type and so on. By using this explicit terminology, a relationship among all drugs of abuse is indicated, but the specific pattern of the dependence is differentiated according to the causative agent(s).

- The drugs that are subject to abuse may also be classified on the basis of their characteristic pharmacologic effect on the central nervous system (CNS), i.e., general depressants, narcotic analgesics, stimulants, and psychedelics (hallucinogens). Within any of these principal groups, agents may then be classified further into subgroups to clarify the particular type of drug dependence involved in specific cases.

- A variety of agents used widely for subjective purposes have in common the ability to produce a nonspecific but generalized depression of the central nervous system (CNS). Included in this category are: ethyl alcohol; the sedative-hypnotics, principally the barbiturates, but also nonbarbiturate agents; the so-called minor tranquilizers; and anesthetic agents.

- All the general depressants of the CNS are abused to one degree or another for similar reasons: the drugs act to allay anxiety and decrease tension.

- All the agents in this group produce the same dose-related signs and symptoms characteristic of increasing depression of the central nervous system. The agents also resemble each other with respect to the pattern of development of psychological dependence, and the degree of tolerance acquired with continued use. Physical

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

dependence also develops to all these agents, and the discontinuance of the use of any of them produces similar symptomatology.

DEFINITION

Cross Dependence

The ability of one drug to suppress the manifestations of physical dependence induced by another, and to substitute for the other in maintaining the physically-dependent state.

- The drugs are essentially additive and interchangeable; they show cross-dependence--the ability of one drug to suppress the manifestations of physical dependence induced by another and to substitute for the other in maintaining the physically-dependent state. Such similarities among the general depressants of the central nervous system justify describing the dependence developed to any one of them under a single category.
- The barbiturates and alcohol are used as the standards of reference for the entire group, and the type of dependence is termed "drug dependence of the barbiturate-alcohol type."
- Alcohol and the barbiturates, at all doses, produce a primary and continuous depression of the central nervous system.

DEFINITION

Potentiation (Synergism)

When more than one substance (drug) is taken, *antagonism* may occur. One compound may offset the action of the other -- the combined effect of two drugs is less than the sum of the effects of the two drugs acting separately.

- Potentiation is the more common action; potentiation literally means "to endow with power. Synergism is the more descriptive term, since most combinations don't produce a simple

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	additive effect. Synergism refers to different situations in which the combined effect of two (or more) drugs acting simultaneously is greater then the effect of each agent added together. Synergism means that the joint effect of two drugs is greater than the algebraic sum of their individual effects. *Placebo Effect* When the effects of a drug are temporarily correlated with its administration and cannot be attributed to its chemical properties an inert substance disguised as a drug, such as sugar lactose, it is called a placebo. (Latin translated as "I shall please.")
5 minutes	• Ask group members if they have any questions about the material discussed so far. If so, respond accordingly.
15 minutes	LECTURE: NARCOTIC ANALGESICS • State the following: - The drugs I am going to talk about are those psychoactive substances with abuse potential. In order to understand more about substances, we need to know something about the substance being used. This calls for at least two more definitions. Since the terms are used interchangeably, the distinction is often confusing. The two terms are "narcotic" and "opiate" or "opioid."
	DEFINITION *Narcotic* - *Legal Term:* includes drugs with morphine-like activitiy, as well as marihuana and cocaine; the last two drugs are pharmacologically unrelated to morphine and induce entirely different states of dependence.

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	- *Medical Term:* applies only to drugs having both analgesic and sedative action; the term embraces essentially only those drugs, either natural or synthetic, that have morphine-like pharmacologic activity. ● State the following: - The term *narcotic analgesic,* used interchangeably with *opiate* or *opioid,* avoids the confusion inherent in the legal classification, and is therefore better terminology to designate the morphine-like drugs. - The drugs classified as opioids, for which morphine is the standard of reference, include the natural opiates, their partially synthetic derivatives, and wholly synthetic opiate-like drugs. Commonly-used opioids include: NOTE: *Be sure you have the following on newsprint, with the same structure as indicated.*

NARCOTIC ANALGESICS

NATURAL OPIOIDS OBTAINED FROM OPIUM

Morphine
Codeine

SEMISYNTHETIC OPIOIDS

Dihydromorphinone (Dilaudid®)
Heroin
Methyldihydromorphinone (Metopon®)

SYNTHETIC OPIOIDS

Phenazocine (Prinadol®)
Meperidine (Demerol®)
Anileridine (Leritine®)
Diphenoxylate (with atropine as Lomotil®)
Methadone (Dolophine®)
Levorphanol (Levo-Dromoran®)

SYNTHETIC OPIOIDS WITH LOW POTENCY AND LOW DEPENDENCE LIABILITY

Propoxyphene (Darvon®)
Ethoheptazine (Zactane®)
Pentazocine (Talwin®)

NARCOTIC ANTAGONISTS

Nalorphine (Nalline®)
Levallorphan (Lorfan®)

- State the following:
  - Although the opioids differ in chemical structure, in their analgesic potency, and in their potential to become drugs of abuse, they have basically similar pharmacologic profiles. Even the narcotic antagonists included in this group, when used alone, have pharmacologic actions like those of morphine. Only the important new antagonist *naloxone* differs in this respect from the other narcotic antagonists.

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	- The opioids are also alike in their ability to induce and maintain some degree of psychological and physical dependence and to develop tolerance. With the exception of the narcotic antagonists, these agents may be substituted for each other to prevent the appearance of the withdrawal syndrome. When the withdrawal syndrome does occur, the signs and symptoms of abstinence are the same for all the opiates. These similarities permit describing the state of dependence developed to any opioid as "drug dependence of the morphine type." - Drug dependence of the morphine type is unique in that the *first* dose of an opioid may set in motion the mechanisms leading to psychological and physical dependence and to the development of tolerance. Dependence can be initiated with small doses well within the therapeutic range; the intensity and rapidity with which dependence and tolerance develop varies with the agent but parallels the increase in dosage. - This is very different from dependence on the central nervous system depressants--which develops gradually and then only when the daily dose is increased appreciably above therapeutic levels. - In contrast to the barbiturate-alcohol class of drugs, the opioids are *selective* depressants of the central nervous system. For example, doses of 5 to 1 mg. of morphine may produce relief of pain without producing any change in the perception of other sensory stimuli (touch, light, sound and so forth); analgesia may occur before and often without sleep. Typically, however, analgesia is accompanied by drowsiness, mood alteration, mental clouding, and some respiratory depression. - An essential feature of the analgesic action of morphine is its ability to alter the *reaction* to pain, rather than merely to decrease the perception of the painful stimulus itself. The narcotic analgesics also relieve anxiety, tension and fear, the reactions evoked by the specific sensation of pain.

- The relief from worry, tension, and fatigue, and the mental fogginess or "other-world" sensation produced by the opioids, are interpreted by some subjects as pleasurable (euphoric). These effects account in large measure for the abuse potential of the narcotic analgesics. However, the naive subject may find the effects of morphine quite unpleasant, with nausea, vomiting, itching, and sweating as the predominant effects. In the compulsive drug user there is a state of *drive satiation:* the drug reduces hunger and diminishes the sexual drive.

- Unlike alcohol, the opiates also suppress aggressive behavior. Violence is characteristic of the compulsive opioid user only when the drug is not available, and he must resort to criminal activity to satisfy his craving. The rapid development of tolerance and physical dependence upon repeated administration reinforces the emotional need to continue taking the drug.

- The rate at which tolerance to the narcotic analgesics develops depends on the rate of administration, and is significant only when administration continues on a more or less daily basis.

- The severity of the abstinence syndrome upon discontinuance of opioid administration is determined by the degree of dependence developed. Although the symptoms of withdrawal are not nearly as serious as those seen upon withdrawal from alcohol or barbiturates, the morphine abstinence syndrome is nevertheless characterized by changes in all major organs and systems.

- Symptoms: appear chortly before the time for the next scheduled dose, intensify over the next several days, then subside gradually and disappear within seven to ten days. The signs and symptoms include: anxiety, restlessness, irritability, lacrimation, generalized body aches, insomnia, perspiration, dilated pupils (except upon withdrawal from meperidine), goose-flesh, hot flushes, nausea, vomiting, diarrhea, fever, increased heart rate and blood pressure, and abdominal

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	and other muscle cramps. The vomiting and diarrhea, combined with an inability to retain water and food, lead to dehydration and loss of weight. - All these symptoms, except dehydration and weight loss, can be suppressed by administering the drug of dependence or another narcotic analgesic. When the abstinence syndrome is precipitated by administration of one of the narcotic antagonists, the symptoms are the same, but the first signs appear within minutes and reach their peak within a half hour. - When the opiate-dependent person is able to obtain his drug by legitimate means, or has adequate funds, and is also able to control his dosage, he can work productively, discharge social obligations, and remain healthy. The capacity of the narcotic analgesics to induce compulsive drug-seeking behavior is their most malignant property. It is more pernicious than for the alcohol-barbiturate drugs with respect to the rapidity with which such behavior can be initiated in susceptible individuals by the repeated administration of small doses.
	• Summarize, highlighting the following pre-prepared items on newsprint as indicated.

<table>
<tr><th>TIME/MATERIALS</th><th>TRAINER ACTIVITIES OUTLINE</th></tr>
<tr><td></td><td>NARCOTIC EFFECTS & SYNDROMES
<table>
<tr><td><i>Psychological Dependence</i></td><td><i>Physical Dependence</i></td></tr>
<tr><td>strong; develops rapidly</td><td>early development, which increases in intensity, paralleling increases in dosage</td></tr>
<tr><td><i>Withdrawal</i></td><td><i>Tolerance</i></td></tr>
<tr><td>severe symptoms but not life-threatening; may be precipitated by administration of narcotic antagonist</td><td>striking degree of tolerance to all but effects on pupil and gastrointestinal tract; cross-tolerance with other opiates or opiate-like drugs</td></tr>
</table></td></tr>
<tr><td>5 minutes</td><td>● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.</td></tr>
<tr><td>15 minutes</td><td>LECTURE: GENERAL DEPRESSANTS
● State the following:
- A variety of agents used widely for subjective purposes have in common the ability to produce a nonspecific but generalized depression of the central nervous system (CNS). Included in this category are: ethyl alcohol; the sedative-hypnotics, principally the barbiturates, but also non-barbiturate agents; the so-called minor tranquilizers; and anesthetic agents.
- All the general depressants of the CNS are abused to one degree or another for similar reasons: the drugs act to allay anxiety and decrease tension.
- The drugs are essentially additive and interchangeable; they show cross dependence--the ability of one drug to suppress the manifestations of physical dependence induced by another, and to substitute for the other</td></tr>
</table>

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in maintaining the physically-dependent state. Such similarities among the general depressants of the central nervous system justify describing the dependence developed to any one of them under a single category.

- The barbiturates and alcohol are used as the standards of reference for the entire group. The type of dependence is termed "drug dependence of the barbiturate/alcohol type."

General depressants are a variety of agents used for subjective purposes. They have in common the ability to produce a nonspecific, generalized depression of the central nervous system (CNS).

NOTE: Be sure you have the following on newsprint, with the structure as indicated:

GENERAL DEPRESSANTS

Ethyl alcohol
Sedative-hypnotics

Barbiturates
Secobarbital
  (Seconal®)
Pentobarbital
  (Nembutal®)
Amobarbital
  (Amytal®)
Phenobarbital
  (Luminal®)
Glutethimide
  (Doriden®)
Methyprylon
  (Nodular®)
Chloral hydrate
Paraldehyde

Minor tranquilizers

Meprobamate
  (Miltown®; Equanil®
  Meprospan®)
Chlordiazepoxide
  (Librium®)
Diazepam
  (Valium®)
Oxazepam
  (Serax®)

General anesthetics

Ether
Nitrous Oxide

Miscellaneous agents
Glue
Paint thinners
Lacquer thinners

- Alcohol and barbiturates, at all doses, produce a primary and continuous depression of the

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

central nervous system. At low doses the effects are principally the result of depression of the reticular system, the more primitive part of the brain concerned with the maintenance of consciousness and the control of responsible behavior. Since the impulses ascending from the reticular activating system to the cortex can be either excitatory or inhibitory, the behavioral responses that are observed will depend on which pathway is depressed initially.

- Thus, the effects of low doses of alcohol and barbiturates are contingent on the degree of excitability of the central nervous system at the time of drug administration. This, in turn, depends on the environmental setting of drug use and on the personality of the user.

- In a quiet, nonsocial environment, the ascending excitatory influence may be impaired, and the sedation and drowsiness produced by the drugs are then equated readily with depression of the central nervous system.

- In a social setting, where there is a great deal of sensory input, the cortex may be freed from its integrating control by depression of the ascending reticular system. Under these circumstances the effects of low doses of drug are perceived as stimulation, whereas in fact they are the result of release from inhibition (secondary to depression) of those pathways of the reticular activating system that inhibit specific areas of the cortex. The paradoxical excitement -- the talkativeness, the heightened vivacity, the increased self-confidence, and the general loss of self-restraint -- may be likened to the situation of an automobile parked on an incline being suddenly set in motion by releasing the brake. There is also loss of mental acuity and judgment and impaired motor coordination.

- As the dose is increased, and during chronic intoxication, these agents produce more of the same effects. There may be slurred speech, staggering, loss of emotional control, stupor from which arousal is difficult, severe respiratory depression, and, finally, coma and death.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- Although low doses of alcohol and barbiturates impair mental and motor functions to one degree or another, it is the untoward effects of high doses that produce the greatest harm to the individual and to society. - In abusive use of alcohol there may be overt pathologic changes in tissues and organs, e.g., the liver, a factor not associated with dependence on other drugs of abuse. Alcohol, unlike other drugs, can be utilized by the body as a source of energy. This supply of calories often suppresses appetite, leading to dietary deficiencies that may be responsible in part for the pathologic conditions seen in chronic alcoholism. - Drug abuse and drug dependence occur in all degrees with the alcohol/barbiturate class of drugs. Abusive use ranges from occasional sprees of gross intoxication to prolonged, daily use, and chronic intoxication. Ethyl alcohol is the agent used most widely. - Mild degrees of psychic dependence may develop to the central nervous system depressant drugs when they are used in low or therapeutically recommended dosage. Although this may lead to their continued use, drug administration may be stopped without any serious subjective disturbances. When there is need for increased drug consumption because of incomplete relief of anxiety and tension, then the development of physical dependence reinforces compulsive use to avoid withdrawal symptoms. - The tolerance that develops to the central nervous system depressants is erratic and incomplete and never reaches the degree observed with the opioids or amphetamines. However, the lethal dose of any of these agents is not much greater in the drug-dependent individual than in the nontolerant subject. - The most distinguishing feature of the alcohol barbiturate type of drug dependence is the abstinence syndrome that appears upon abrupt cessation of prolonged administration of high doses.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- The withdrawal symptoms are usually far more dangerous than those resulting from withdrawal of the opiates, or other agents of abuse to which physical dependence may be developed. - However, the severity of symptoms depends on the length of drug abuse and the degree of intoxication. In the typical course of withdrawal, symptoms begin within the first 24 hours after discontinuance of the drug, reach their peak intensity within two or three days, but are self-limiting and usually disappear within one to two weeks. During the first day of withdrawal there may be headaches, anxiety, involuntary twitching of muscles, tremor of hands, weakness, insomnia, and nausea. - During the next 48 hours the symptoms become progressively more intense: there may be a precipitous fall in blood pressure; fever; delirium characterized by disorientation, delusions and vivid visual hallucinations; and convulsions similar to those exhibited in *grand mal* epilepsy. The fever, delirium, and convulsions are the most serious symptoms and have proved fatal in a number of instances.
	● Summarize, highlighting the following pre-prepared items on newsprint as indicated.

<table>
<tr><th>TIME/MATERIALS</th><th>TRAINER ACTIVITIES OUTLINE</th></tr>
<tr><td></td><td>GENERAL DEPRESSANT EFFECTS & SYNDROMES
<table>
<tr><th>Psychological Dependence</th><th>Physical Dependence</th></tr>
<tr><td>Mild to strong, develops slowly</td><td>Develops slowly but to marked degree</td></tr>
<tr><th>Withdrawal Syndrome</th><th>Tolerance</th></tr>
<tr><td>Varies in intensity with duration and amount of drug intake; potentially severe and most dangerous; characterized by convulsions; deaths not uncommon</td><td>Irregular and incomplete; little tolerance to adverse effects of high doses; cross-tolerance among members of group</td></tr>
</table>
</td></tr>
<tr><td>5 minutes</td><td>● Ask group members if they have any questions about the material just presented. If so, respond accordingly.</td></tr>
<tr><td>15 minutes</td><td>LECTURE: STIMULANTS OF THE CENTRAL NERVOUS SYSTEM
● State the following:
- Drugs may produce increased activity of the central nervous system, either by blocking pathways that normally inhibit activity or by enhancing excitation directly.
- The drugs used for abusive purposes and classified as central nervous system stimulants act, in the main, by direct stimulation. In humans the cortical stimulation is seen as garrulousness, restlessness, increased motor activity and excitement. These stimulants also produce a lessened sense of fatigue, so that physical performance and work may be improved and prolonged when they otherwise would have been impaired by fatigue or lack of sleep. Prolonged use or use of large doses is nearly always followed by lethargy and mental depression.</td></tr>
</table>

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

NOTE: Be sure that you have the following on newsprint with the same structures as indicated below.

CNS STIMULANTS

Amphetamines

Dextroamphetamine (Dexedrine®)
Amphetamine (Benzedrine®)
Methamphetamine (Methadrine®; Desoxyn®)

Cocaine

Phenmetrazine (Preludin®)

Diethylpropion (Tenuate®; Tepanil®)

Methylphenidate (Ritalin®)

Mephentermine (Wyamine®)

Caffeine

Nicotine

- The amphetamines and cocaine are the principal agents of abuse among the stimulants of the central nervous system. They differ significantly in many of their pharmacologic actions, but are remarkably similar in their subjective effects, toxic symptoms, and present-day patterns of abuse. We shall therefore use amphetamines as the standard of reference for the group, and indicate the ways in which dependence on cocaine differs from that for amphetamines.
- The ability of the amphetamines to elevate mood, combat fatigue, reduce appetite, and induce a general state of well-being accounts for their widespread use as stimulants and appetite suppressants. These effects are typical and occur even in those using the drugs for the first time. This is in contrast to the effects of the opioids, which many first-time users find unpleasant.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- Tolerance does not develop evenly to all the central nervous system effects, and the user may show increased nervousness and persistent insomnia as the dose is increased. After weeks or months of continued use, a toxic psychosis resembling schizophrenia may develop, characterized by delusions and hallucinations, both auditory and visual. These psychological disturbances can also appear within a day or two after ingestion of a single large dose, but usually disappear within a week after use of the drug is discontinued. - Abrupt discontinuance of the use of amphetamines does not lead to a physiologically disruptive state, and withdrawal of the drugs is never life-threatening. Upon abrupt withdrawal there is a period of prolonged sleep, lethargy, and often a precipitous depressive reaction. This state of depression, both psychological and physical, probably motivates continuation of drug use. There is a growing consensus that these symptoms, which appear regularly when the amphetamine-like drugs are discontinued, constitute a mild form of abstinence syndrome. Similar symptoms appear when the use of cocaine is terminated abruptly. But since tolerance to cocaine does not develop, these symptoms are not considered evidence for the development of physical dependence.
	Summarize, highlighting the following pre-prepared items on newsprint as shown.

TIME/MATERIALS | TRAINER ACTIVITIES OUTLINE

CNS STIMULANT EFFECTS & SYNDROMES

	Psychological Dependence	Physical Dependence
Amphetamines	Mild-to-strong	Low degree
Cocaine	Strong	None

	Withdrawal Syndrome	Physical Dependence
Amphetamines	Mild	Marked but incomplete; cross-tolerance with amphetamine-like agents but not with cocaine.
Cocaine	None	None

- State the following:

- The hyperactivity, the feeling of great muscular strength, the paranoid delusions and the auditory and visual hallucinations often combine to make the stimulant user a dangerous individual capable of committing serious antisocial acts.

- Chronic users of amphetamines are also prone to accidents, since they are unaware of their fatigue until it overcomes them at an inopportune time.

5 minutes

- Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.

15 minutes

LECTURE: PSYCHEDELICS (HALLUCINOGENS)

- State the following:

- The term *hallucinogen* designates a drug that acts on the central nervous system to produce a state of perception of objects with no reality, or of sensations with no external cause.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

- The word *psychedelic* meaning mind-manifesting, was coined to distinguish the hallucinogens from other classes of drugs that can, under certain conditions, produce similar effects. A psychedelic drug is defined as one that is self-administered for its capacity to reliably cause marked changes in mood, judgment, and perception that are not, or cannot be, experienced except in dreams or religious trances.

- Thus the term psychedelic delineates the hallucinogens in terms of the purpose for which they are used. And, with the exception of atropine and scopolamine, the psychedelics have little or no recognized therapeutic use.

NOTE: Be sure you have the following on newsprint with the same structure as indicated below.

HALLUCINOGENS

LSD-25 (lysergic acid diethylamide)

Dimethyltryptamine (DMT)

Psilocybin

Psilocin

Phencyclidine (PCP)

Diethyltryptamine (DET)

Dipropyltryplamine (DPT)

Dimethoxyphenylisopropylamine (DOM [STP])

Methylenedioxyamphetamine (MDA)

- State the following:

- As little as 20 to 25 micrograms of LSD may produce effects in susceptible individuals, and these may last from eight to twelve hours. The nature of the psychedelic state induced is not predictable in advance and is influenced by the setting of drug use as well as by the mood and expectations of the user.

- Although marked tolerance develops rapidly to the behavioral effects of LSD, it also disappears quickly. Since no physical dependence develops, the user has little compulsion to increase dose or to continue use to avoid the discomfort of its absence. The real and potential hazards of the psychedelic drugs lie in the unpredictability and unreliability of the effects that they can produce.

- Acute reactions, estimated to occur in about ten percent of those who experiment with LSD or related drugs, are of short duration and are usually treatable by reassurance or by sedative drugs or tranquilizers. The acute psychotoxic reactions may be characterized by uncontrollable excitement, confusion, acute paranoia, or all of these. The acute panic reactions appear as secondary responses to drug-induced effects. The sensory distortions and powerful emotions elicited by the drug produce in some individuals an overwhelming tension and anxiety, a fear of losing one's mind, and an abject sense of helplessness.

- Recurrent reactions may appear up to a year after the last use of drug, and without further exposure to the psychedelic. They usually involve the spontaneous return of perceptual distortions and a reliving of the earlier traumatic experiences. These "flashbacks" can vary in length from a few seconds to a half hour, but occur unpredictably.

- Prolonged reactions can be exhibited as chronic anxiety states, or chronic psychoses. The former are a relatively common occurrence and are accompanied by time and space distortion, difficulty in functioning, and depression stemming from the morbid or terrifying feelings or thoughts experienced during drug use. It is not certain whether the small number of individuals who develop prolonged psychotic reactions would have developed these same conditions in the absence of the use of psychedelic drugs.

- Phencyclidine (PCP, "Angel Dust"), often sold as THC.

  Because of its markedly different effects at varying dose levels, it cannot be placed accurately in the "standard" stimulant/depressant or hallucinogenic categories of psychoactive drugs. It was developed in the late 1950s and--following pharmacological, toxicological, and metabolic studies in laboratory animals--it was recommended for clinical trials in humans in 1957.

  Parke, Davis and Company marketed the drug under the trade name Sernyl^{R}. Originally the drug was used as an anesthetic agent in surgical procedures and although found to be generally effective, it often produced unpleasant side effects. Upon emergence from anesthesia, some patients experienced extreme excitement, visual disturbances, and delirium. Other therapeutic investigations of PCP were for potential use as a pain killer, and for treatment and understanding of mental disorders. However, at present it is available commercially for "veterinary use only" under the trade name Sernylan® and distributed solely by Bio-Centric Laboratories.

- The site and mode of action of phencyclidine is as yet unclear, although studies indicate that the drug acts on the sensory cortex, thalamus, and midbrain in such a manner as to "scrabble" external stimuli, thereby impairing perceptual functioning. It does tend to depress the central nervous system and in low doses (depending upon the route of administration) it produces a state similar to alcohol intoxication, including muscular incoordination and generalized numbness of the extremities. Moderate doses produce analgesia and anesthesia -- sensory disturbances or blockade, muscular rigidity, and possible loss of contact with one's environment. Large doses can produce convulsions.

- Experiences reported under phencyclidine are mainly nondescript or unpleasant ones. In sub-anesthetic doses, the experience usually proceeds in three stages:

1. Changes in body image, sometimes accompanied by feelings of depersonalization.
2. Perceptual distortions infrequently evidenced as visual or auditory hallucinations.
3. Feelings of apathy or estrangement. The experience often includes feelings of drowsiness, inability to verbalize, and feelings of "nothingness" or "emptiness". Reports of difficulty in thinking, poor concentration, and a preoccupation with death are frequent.

- In laboratory tests, PCP did not depress circulation or respiration, nor disturb cardiac rhythm, but a moderate slowing of the EEG pattern has been found. Pain response has been found to be blocked, and at 10.5 mg drowsiness appeared. Common peripheral signs of PCP include flushing, profuse sweating, and mild relaxation of the arteries. Analgesia, nystagmus, muscular incoordination, double vision, and dizziness (perhaps resulting in nausea and vomiting) may occur.

- PCP is usually taken orally or through inhalation (by smoking PCP sprinkled, as "Angel Dust" on parsley, marihuana, or other smokable substances). Because it has not proven to be a drug of choice it has often been mislabeled and sold as some other desirable psychedelic drug, especially as THC. In 1970 an illicit and mis-synthesized batch found in the Midwest proved to be a very toxic substance. Apparently PCP is synthesized primarily in illicit laboratories, rather than diverted from legally-produced supplies. It is produced in powdered form both alone and in combination with other drugs, often LSD, and sold in gelatin capsules.

- Phencyclidine (PCP) has not been found to be a "drug of choice" by either the medical profession (for therapeutic uses) nor by the drug-using population (for its subjective qualities). Generally, phencyclidine is sold on the street under the disguise of another label, such as THC (which has never really been available for

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street use).

- We need to give our youth information about the risk factor in drugs. For example, kids hear that THC (tetrahydrocannabinol), the active ingredient in marihuana, is available in a black market capsule called phencyclidine, the peace pill, which was developed as a veterinary anesthetic. In other words, it makes a dog hallucinate, which is why it was never released for humans.

- Summarize, highlighting the following pre-prepared items on newsprint, as indicated below:

HALLUCINOGEN EFFECTS & SYNDROMES

Psychological Dependence	Physical Dependence
Variable	None
Withdrawal Syndrome	Tolerance
None	Marked

- State the following:

- The most common pattern is an occasional use at weekly or monthly intervals. Following initial exposure, regular use of LSD is the exception rather than the rule. Even among chronic users, hallucinogens are rarely taken more than twice a week. Although marked tolerance develops rapidly to the behavioral effects of LSD, it also disappears quickly. Since no physical dependence develops, the user has little compulsion to increase dose or to continue use to avoid the discomfort of its absence.

- The real and potential hazards of the psychedelic drugs lie in the unpredictability and unreliability of the effects they can produce,

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	and in the frequency of unpleasant or disastrous experiences ("bad trips"). The syndromes produced by these psychedelics are psychologically harmful to the individual and may be manifested as either acute, recurrent, or prolonged reactions. - The acute reactions, estimated to occur in about ten percent of those who experiment with LSD or related drugs, are of short duration and are usually treatable by reassurance or by sedative drugs or tranquilizers. The acute psychotoxic reactions may be characterized by uncontrollable excitement, confusion, or acute paranoia--or all of these. The acute panic reactions appear as secondary responses to drug-induced effects. - The sensory distortions and powerful emotions elicited by the drug produce in some individuals an overwhelming tension and anxiety, a fear of losing one's mind, and an abject sense of helplessness. In the grip of such reactions the individual may expose himself to dangerous situations or engage in behavior that threatens his life. - Deaths attributable to the direct actions of hallucinogens are unknown, but deaths by drowning, falling out of windows, and walking into the path of automobiles have occurred. It is immaterial whether such deaths were accidental or suicidal. - Although the psychological and social dangers associated with the use of LSD-like drugs are incontrovertible, the evidence for drug-induced chromosomal abnormalities and projected dangers to the unborn human remains equivocal. - Since use of any drug during gestation can entail a certain risk to the fetus, the better part of wisdom dictates the avoidance of psychedelics as well as other drugs during pregnancy (alcohol, marihuana, etc.).
5 minutes	● Ask group members if they have any questions regarding the material presented thus far. If

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	so, respond accordingly.
15 minutes	LECTURE: CANNABIS SATIVA (MARIHUANA) ● State the following: - Marihuana is the common name for the hemp plant, *Cannabis sativa.* The hemp plant Cannabis Sativa is the source of the ancient drug cannabis and its products variously referred to as *hashish, charas, bhang, ganja, dagga,* and *marihuana.* Only the female plant yields the active ingredients, most of which are concentrated in the flowers. - Historically, hemp fibers have been used for making textiles and rope, the seeds used for the oil they contain, and the leaves and flower parts consumed, usually smoked, for the intoxicating effects of the resin they secrete. In the Middle East and North Africa the resin is called hashish. In the United States, the term marihuana is used to refer to any part of the plant or its extract.
	NOTE: Be sure you have the following on newsprint, with the same structure as indicated below.
	Cannabis Marihuana Hashish Hashish Oil
	● State the following: - The chemical in marihuana with the greatest mood-altering effects is believed to be delta-9-tetrahydrocannabinol (THC), though the leaves and flowers contain many related chemicals. Marihuana appears as dried leaves and flower parts, with or without seeds and stems, ranges in color from greenish-brown to

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

gold or dark brown, and may contain from zero percent to five percent THC.

- Hashish is made by removing the strong-smelling resin secreted by the leaves and pressing it into cakes or slabs, and is usually more potent than marihuana, having up to 12 percent THC. Hashish oil, a highly-refined form of marihuana, can contain up to 50 percent THC. Pure THC usually is not available because it is very expensive to produce and loses its potency rapidly upon exposure to air. Substances sold as THC usually turn out to be PCP, an animal tranquilizer, which can cause unpredictable reactions in many people.

- Summarize, highlighting the following pre-prepared items on newsprint, as indicated below.

CANNABIS EFFECTS & SYNDROMES

Physical Dependence	Psychological Dependence
Degree unknown	Moderate
Withdrawal	**Tolerance**
None	Reverse Tolerance

- State the following:

- As with LSD, the subjective effects produced by marihuana are influenced by the state of mind, mood, and expectations of the user, and by the specific circumstances in which the drug is used.

- There is a need for more research on marihuana and driving. Reports show that some sensory impairment can occur, but the degree to which this affects driving ability has not been made clear.

- Though it is known that smoking marihuana irritates lung tissues, the extent to which tars from marihuana are capable of causing cancer is

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TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

still under investigation. One report suggests that tobacco and marihuana smoke in combination may be more carcinogenic (cancer-producing) than either is alone.

- While there is no substantiated evidence to show that marihuana is harmful to fetal development or damaging to chromosomes, the use of all drugs by pregnant women should be kept to a minimum due to the lack of knowledge in this area.
- A study done by the Reproductive Biology Research Foundation reported that a group of 20 young male marihuana smokers had a blood level of the male sex hormone testosterone that was 44 percent lower than in a non-marihuana smoking group. This implies that smoking marihuana could disrupt the development of male characteristics in fetuses (when used by pregnant women) or could delay the onset of puberty (when used by pre-adolescent males). Neither of these possibilities has been studied, nor have the findings been confirmed by another group doing the same experiment.
- Another report that marihuana interferes with the body's ability to resist disease has not been confirmed. Marihuana smokers do not seem to suffer a higher rate of disease than non-smokers and follow-up studies on this subject have conflicted with the original conclusions.
- One study on the long term effects of marihuana use among farm laborers in Jamaica found no significant physical abnormalities in any of the heavy marihuana smokers, nor did the chromosomes of their offspring differ from those of non-users.
- A review of the wealth of available material on marihuana's psychological effects reveals common agreement that the use of small daily doses causes no lasting interference in psychological functioning. There is some evidence, however, that chronic users of very high daily doses are more likely to show signs of mental deterioration and abnormal behavior than the general population.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- Whether prolonged, extremely high dosage, marihuana use is the cause or merely a possible symptom of psychological or emotional disturbance remains to be proven. Any drug --any substance--is abusable. A case of marihuana abuse, though, would seem to say much more about the condition of the abuser than the danger of the drug.
	- The effects of smoking depend, in large part, on the mood and expectations of the user and the setting in which marihuana is used. Because the effects vary from user to user, marihuana is classified in a category of its own rather than as a hallucinogen, stimulant, or depressant. Of course, the size of the dose taken is also important; some marihuana may produce no effect at all while a small amount of very potent marihuana may produce a marked reaction in some people.
	- The most consistent effects seem to be feelings of exhilaration and relaxation, and a minor increase in heart rate (which increases with the size of the dose). Other effects may include hilarity, drowsiness, dry mouth, and bloodshot eyes. Higher doses sometimes induce confusion or inability to concentrate, while occasionally, some users may experience rapid mood changes, depression, or panic. Reassurance and a calm environment can aid a person having an unpleasant experience with marihuana.
	- No short term or long term hazards from the occasional use of marihuana have been verified. However, we know little about how marihuana actually works in the body. No drug can be considered safe for all people at all dosage levels and in all circumstances.
	NOTE: For more complete information about studies see Marijuana: The Health Questions, The Legal Questions, *available from the Wisconsin Clearinghouse and* New Facts About Marijuana, *DO IT NOW Foundation, P.O. Box 5115, Phoenix, Arizona 85010.*

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- Some research suggests that the long term use of marihuana may result in psychological dependence or habituation (craving the intoxication), chronic lethargy, and, when smoked, lung damage. These hazards have not been shown to occur consistently and it is not known what proportion of marihuana users may suffer from such hazards. - Although it is known that many marihuana users also use other drugs, it is not known what proportion of them engage in polydrug use. It is also not known which drug other than alcohol is used first most often. - So far a number of states have chosen to reduce greatly the penalties for simple possession of marihuana. Some reasons for this include: to reduce the overload of the court systems; that harsh penalties do not discourage marihuana use; and that marihuana is a mild intoxicant, and penalties for its private use should reflect the actual danger to society that use presents. - In these states, marihuana has been decriminalized. That is, the criminal penalties for its possession have been replaced with penalties similar to those for civil offenses such as parking violations. For example, instead of being sent to jail, a person apprehended with one ounce or less in his or her possession might be fined $100. Decriminalization differs from legalization in that legalization would eliminate altogether penalties for possession, sale, or distribution, while decriminalization merely reduces the penalty for possession of marihuana. - One might expect that lessening penalties would invite further use of the drug. A study done in Oregon after the new law went into effect has shown that is not the case. It seems that most non-users choose not to use the drug because of reasons other than its illegality.
5 minutes	● Ask group members if they have any questions regarding the material presented thus far. If so, respond accordingly.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
20 minutes	LECTURE: RELATIVE HAZARDS • State the following: - What all drugs with a potential for abuse have in common is the ability to induce some desired perceptual or feeling change in the individual. The more desirable and seductive this change is, the greater potential the drug has for creating psychological dependence and abuse. However, drugs within each category can differ. - Among the narcotics, the abuse potential is lower with methadone and codeine than with heroin; among the stimulants caffeine possesses a much smaller abuse potential than does methamphetamine or cocaine. Similarly, not all narcotics produce significant physical dependence; that from codeine and d-proposyphene (Darvon®) is of little consequence. - When taken in the usual non-medical (social) doses, judgment is impaired only by the hallucinogens and general depressants (glue ingredients, hypnotics, minor tranquilizers, and alcohol). However, very high doses of stimulants and marihuana can produce psychotic, stereotyped behavior with greatly-impaired judgment. - This reaction is particularly hazardous with cocaine and the amphetamines, where excitement and paranoid delusions combine to make the individual possibly dangerous to others. Significant tissue damage or body injury can be produced only by some glue vapors, alcohol, and tobacco. Chromosomal damage to other than the peripheral blood cells of the user or fetus of LSD-using mothers still remains an object of inquiry (to be substantiated); there is no convincing or substantive evidence at present for the occurrence of gross fetal abnormalities or leukemia following the use of LSD-25. - An assessment of the relative hazards of the psychoactive drugs with abuse potential was undertaken by Dr. Samuel Irwin. This assessment involved a series of complex judgments (often based on incomplete or inadequate

information) and it is doubtful that other experts would uniformly agree on any rank ordering of the drugs, or on any decision-making criteria and priorities established for doing so.

- Nonetheless, Irwin attempted to make such a judgment based upon such criteria as the drugs' overall potential to do the following:

NOTE: Be sure you have the following on newsprint, with the same structure as indicated below.

CRITERIA FOR HAZARD POTENTIAL

1. To be used repeatedly or compulsively
2. To be taken intravenously
3. To be used in a self-destructive manner
4. To produce physical dependence
5. To impair judgment
6. To predispose to social deterioration
7. To produce irreversible tissue damage and disease
8. To cause accidental death from overdosage

NOTE: Be sure you have the following on newsprint, with the same structure as indicated below.

- State the following:

- Here are the results of that assessment by Dr. Irwin.

TIME/MATERIALS | **TRAINER ACTIVITIES OUTLINE**

RATING OF INTRINSIC HAZARD POTENTIAL TO THE INDIVIDUAL

	Scale	Substance
(1)	High	Glue Sniffing
(2)		Methamphetamine (Speed)
(3)		Alcohol
(4)		Cigarette Smoking
(5)		Barbiturates & Hypnotics
(6)		Heroin & Related Narcotics
(7)		LSD-25 and Other Hallucinogens
(8)	Low	Marihuana

- This is Dr. Irwin's rating (from high to low) of the intrinsic hazard potential to the individual of the various agents in use.

- Glue sniffing was rated highest because of the ensuing rapid loss of control and consciousness, leading to possible overdosage and death from respiratory arrest, and to its ability to produce irreversible damage to the brain and body tissues.

- Methamphetamine (or "speed"), especially when taken intravenously, was rated second because of its high psychological dependence liability (it is too pleasurable). It also predictably produces a paranoid schizophrenic state with greatly impaired judgment, excitement, and a tendency for violence after repeated use of doses three or more times what a physician might prescribe.

- Especially with the stimulants, users are tempted to seek more intense effects by taking the drug by injection. This leads to further impairment of functioning, a high probability of loss of control, great physiological impairment from loss of sleep and appetite, a possibility of hepatitis (serious inflammation of the liver) or septicemia (infection by bacteria) from the use of unsterile materials, and a probable need for protective hospitalization. All this is summarized by the common catch phrase, "speed kills."

- Alcohol was ranked third because it has high potentials for psychological and physiological dependence, greatly impairs judgment and coordination (a leading cause of driving accidents), increases aggressiveness and violent behavior, often produces marked social deterioration, and causes irreversible damage to the brain, liver, and other body tissues. The withdrawal symptoms (*delirium tremens*) from alcohol abuse are also often life-threatening and difficult to treat.

- Cigarette smoking is listed fourth because of the high incidence of irreversible damage (to lungs, heart and blood vessels) and cancer formation accompanying its prolonged use. These hazards reduce the life span greatly and often debilitate the individual long before death.

- Barbiturates and hypnotics were ranked fifth because, although similar to alcohol in their overall effects and dependence liability, they do not cause tissue damage (except after coma-producing dosages). A greater danger with the hypnotics, however, is the increased possibility of death from overdosage.

- Heroin and related narcotics were rated sixth because, unlike alcohol and the barbiturates, they do not impair coordination and judgment in normal doses, do not produce tissue damage and are more likely to inhibit aggressive behavior. When taken intravenously, these drugs are potentially very addictive, both psychologically and physically, and their continued use can lead to social deterioration. But, the physical dependence would be of little consequence if the drug were available freely, and sufficient tolerance develops to the depressant effects so that it is possible to function more productively under the influence of heroin than with alcohol or barbiturates.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- The main danger from heroin (or morphine) is acute respiratory failure and death from overdosage during initial use, as a very narrow margin exists then between the effective dose and the lethal dose. With illicit supplies varying greatly in potency, this represents a serious danger. Because unsterile materials are often used for injection, there is also the possibility of developing hepatitis and septicemia. - LSD-25 and other hallucinogens are seventh on the list because, although they can cause psychotic reactions, such occurrences are relatively rare (less than one percent of volunteers in clinical settings have prolonged adverse reactions, and the rate for the general population of illicit users is probably less than five percent). LSD is not an addictive drug in the usual sense; it is taken intermittently and its use is usually discontinued gradually. - The hallucinogens produce no physical dependence, but pose hazards in the psycho-social realm, triggering psychotic or depressive reactions in susceptible individuals, and opening up the possibility of flashbacks of LSD-like effects even months after the last dose (attributed by some clinicians to hysterical reactions associated with unresolved conflicts). For some, the LSD experience can profoundly modify personal attitudes and life style, not necessarily detrimentally. The lethal dose is so high that no human deaths have been reported from overdosage. - Marihuana is ranked last in intrinsic hazard because there have been fewer untoward reactions from its use requiring treatment or hospitalization than from any other type of psychoactive drug. Also, marihuana is more prone to reduce aggressiveness than to increase it. Psychological dependence to the drug is not as great a hazard as it is with alcohol; there is little tolerance development, no danger of physiological dependence, and no significant tissue damage associated with its use.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- In small and moderate doses there seems only minor impairments of judgment or coordination and hallucinogenic-like effects are relatively difficult to achieve by smoking (they can occur when the drug is taken orally, a route that leads to a much less predictable drug effect). Like LSD the lethal dosage of marihuana is so high that it is extremely difficult to kill oneself from overdosage.
5 minutes	● Ask group members if they have any questions. If so, respond accordingly.
5 minutes	● Summarize by stating the following: - In the same assessment conducted by Dr. Irwin he showed a similar rank ordering of the drugs (from high to low) in terms of their intrinsic hazard potentials to society, an even more complex judgment to make. This is based largely on the extent of the drugs' probable misuse and subsequent harm to others e.g., through social deterioration, crimes of violence, apathy, and driving accidents. He compared his own assessment with one compiled from judgments by 22 representatives of law enforcement agencies (mainly district attorneys) at the Western Institute of Drug Problems (held in summer, 1969). He considered alcohol the most potentially hazardous of all the drugs. - Ratings by the law enforcement personnel listed heroin as the highest. These were listed as 100 percent and the estimates of hazard of all the other drugs were rated in relation to this value for alcohol and heroin respectively (e.g., heroin was considered by Irwin as 40 percent as hazardous as alcohol). - The law enforcement group tended to rate the hazard of drugs in accord with the existing laws and penalties, except for marihuana, which was rated by them to possess low hazard potential (only slightly above alcohol on the scale).

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

- Most remarkable was their low rating of alcohol, which has been listed as the fourth major public health hazard in the United States. Their own experience in law enforcement has revealed alcohol to be implicated in over 50 percent of driving fatalities and countless crimes of violence; to occupy over 50 percent of their enforcement time, and about one-third of the total police budget.

- Most of the pills, capsules, and powders prepared and sold illicitly are done so with little regard for human safety. The level of fraud in the illicit market is appalling, as is the evident lack of quality control over composition, dosage, and potential toxicity of most of the drugs sold. In consequence, one assumes considerable risk in ingesting or injecting illicit material. All too often the drugs are not what they are claimed to be, contain too high a dose for safe use, or are cut with chemicals intended to mimic a drug's action, chemicals that may have more dangerous potentials than the drug purported to be in the pill.

- For example:

  1. virtually all the "mescaline" or "psilocybin" sold illicitly contains either LSD or STP (DOM);

  2. much of the "LSD" sold has been STP (DOM) or the more dangerous (higher "freakout") combination of "speed" with belladonna;

  3. most of the "THC" sold has been phencyclidine or some other agent, for THC has almost never been available on the illicit market; and

  4. the "heroin" sold is cut with additives that have caused a high incidence of sudden deaths following injection.

- Unusual adverse reactions experienced frequently are blamed on the presence of strychnine in the drug (rather than to its impurities and potential toxicity), but fortunately strychnine has rarely been found in illicit drug samples tested.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- It is claimed that about half the quantity of barbiturate and amphetamine pills manufactured legitimately are siphoned off into the illicit market.
10 minutes	BREAK
75 minutes	PROGRAMMED LEARNING EXERCISE ● State the following: - We have covered a lot of material in this module. In order to assist you in "digesting" the content, we are going to use programmed instruction. Programmed instruction is self-teaching. You work through the material at your own pace. This program will probably take you from one to one and one-half hours to complete. - I would like you to locate *"What Will Happen If... An Individual Learning Program,"* in your *Resource Manual* on page V-3. Please read the instructions at the front of the programmed instruction and begin to work immediately. - If you need any assistance, please raise your hand and we will try to assist you in any way possible. - Please begin your work. ● Provide assistance only as requested. ● Ask the group to stop at the end of one hour and 15 minutes.
10 minutes	● If there are people who express difficulty in coming up with the right answer, ask them to read certain topic areas in the appendix or supplemental reading material. END OF MODULE

REFERENCES

Irwin, Samuel. "The Uses and Relative Hazard Potential of Psychotic Drugs." *Grassroots*, September, 1974, supplement, 11-26.

Levine, Ruth R. *Pharmacology: Drug Actions and Reactions.* Boston: Little, Brown and Company, 1973, 330-348.

MODULE VI

UNDERSTANDING AND OVERCOMING SUBSTANCE DEPENDENCE

MODULE VI: UNDERSTANDING AND OVERCOMING SUBSTANCE DEPENDENCE

PERSPECTIVE

The purpose of this module is to provide information on - and to give participants new ways to consider - the physiological aspects of substance dependence and their relation to individual tension levels. This module also focuses on the forms of treatment that are used to overcome chemical dependence.

This module includes:

- Overview of Module VI (5 minutes)
- Lecture/Discussion: Narcotic Addiction and Alcoholism (25 minutes)
- Lecture/Illustration: Tension Levels (15 minutes)
- Lecture/Illustration/Discussion: (20 minutes)
- Lecture/Discussion: Treatment of Substance Dependence: An Overview (20 minutes)
- Lecture/Discussion: Present Methods of Treatment: An Overview (15 minutes)
- Lecture/Discussion: Treatment for Non-opiate Drug Dependence (10 minutes)
- Lecture/Discussion: Drug Abuse Treatment Modalities: An Overview (80 minutes)

TOTAL TIME: 3 hours, 30 minutes

OBJECTIVES

Using the information presented in Module VI as criteria, at the end of this module, and without the aid of notes, participants will be able to:

1. Identify the difference between the withdrawal syndromes of heroin and alcohol.

2. Identify at least three commonalities of heroin and alcohol.

3. Identify at least three reactions to consumption of sedative hypnotics (particularly alcohol) that can lead to convulsions.

4. Identify at least three reactions to consumption of sedative hypnotics (particularly alcohol) that can lead to coma.

5. Identify at least one advantage and one disadvantage of each of these treatment methods:

   - methadone maintenance

   - therapeutic communities

   - extended group psychotherapy.

MATERIALS REQUIRED

- Lecture Outline: Narcotic Addiction and Alcoholism
- *Alcohol and Heroin* Chart
- *Reactions to Sedative Hypnotics (Particularly Alcohol)* Chart
- *Average Tension Level* Chart
- *Tension Changes Due to Alcohol Consumption* Chart
- *The Build-Up Effects of Additional Alcohol Consumption* Chart
- *Hair-Of-The-Dog Effect* Chart
- *Effects of Higher Alcohol Dosages* Chart
- *Tension Levels Produced by 48 Hours of High-Level Alcohol Consumption* Chart
- *Stan Abuse* Comic Strip
- Lecture Outline: Treatment of Substance Dependence: An Overview

- Lecture Outline: Present Methods of Treatment: An Overview
- Lecture Outline: Treatment for Non-opiate Drug Dependence
- Lecture Outline: Drug Abuse Treatment Modalities: An Overview
- *"Drug Abuse Treatment Modalities: An Overview,"* by Stephen Pittell, *et al.*
- *"Overcoming Substance Dependence,"* by H. Stephen Glenn, Joel Warner, and Richard Hockman
- Large Group Meeting Space
- Markers, Tape and Newsprint

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	OVERVIEW: MODULE VI ● Review the objectives of Module VI with the total group. ● Explain the sequential flow of the module by highlighting: - Large group introduction to the content - Lecture presentation by the trainer - Large group discussion ● Introduce the module as follows: - Earlier modules have stressed the need for accurate definitions of substance abuse terminology. An understanding of three pharmacological concepts--tolerance, physical dependence, and psychological dependence--should serve to establish a clearer conceptual understanding of substance dependence. - Generally, substances most frequently associated with dependence are those with pain-killing potential. Pain of any kind--social, psychological, or physical--produces stress, tension, and anxiety in the individual. Pain killers work by suppressing pain, by altering the ability to respond to pain, or by reducing the tension and/or anxiety caused by pain. Most pain-killing drugs do not eliminate the source of pain. The user takes the drug to relieve discomfort and to make the pain more bearable.
15 minutes	LECTURE: NARCOTIC ADDICTION AND ALCOHOLISM ● State the following: - Dependence on alcohol or other general depressants (such as barbiturates and meprobamate) is markedly more difficult to produce than heroin addiction. Once established, however, those dependencies become far more hazardous to the individual.

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	- During severe withdrawal from such depressants, grand mal seizures and severe psychosis may occur. Even among patients under intensive care, there is a relatively high incidence of mortality. On the other hand, heroin abstinence, although extremely uncomfortable, rarely results in death. - Addiction to either alcohol or to narcotics will cause similar metabolic changes in the body. - When alcohol or narcotics first enter the body, they upset natural functioning of cells. If either drug is used regularly, the physiological processes adapt to its presence and eventually begin to function normally. When use of the substance is discontinued, cells, having adapted to presence of the substance, again function abnormally. The user experiences discomfort either: until more of the substance is taken, or until his cells can re-adapt to absence of the substance. - Once the body processes return to normal, the user may still experience psychological effects (and some psychosomatic dysfunctions) that are as real as the physical problems induced by the substances. Any user who wants to abstain permanently must develop nonchemical resources for coping with stress and tension. - Here, the alcohol user encounters additional problems not experienced by the narcotics user. Narcotics are illegal and socially unacceptable. If the user changes his life style and associations by removing himself from the drug subculture, most of the pressure to use narcotics is eliminated. In contrast, alcohol use is legal, socially acceptable, and frequently expected--with the result that the user attempting to abstain is faced with both continuing temptation and social pressures to keep on drinking. - In terms of incidence of use, complications resulting from acute overdose, long-term effects on the individual's physical and mental state, and ultimate cost to society, there is no close second to alcohol.

- Heroin, divorced from its emotional overtones, has proven pharmacologic and medicinal benefits. It is an excellent suppressant of diarrhea and cough. It is a highly effective short-acting pain reliever.

- Considering solely the personal costs of drinking problems, the price is high. The life expectancy of alcoholic drinkers is shorter by 10 to 12 years than that of the general public. Their mortality rate is at least two and one-half times greater, with a high incidence of violent deaths.

- Alcoholism appears as the cause of death on more than 13,000 death certificates issued each year. Undoubtedly, alcohol and its abuse in fact contribute to many deaths which are attributed to other causes.

- Effects of alcoholism are not felt by the drinker alone. His family, his employer, and society as a whole are all harmed by his behavior, and all have a stake in helping prevent the disease from becoming more severe.

- If one considers the ill effects of drinking as it affects even just the families of problem drinkers, at least 36 million Americans can be seen as victims of alcohol abuse. Unhappy marriages, broken homes, desertion, divorce, impoverished families, and deprived or displaced children are all part of the problem. The cost to public and private assistance agencies for support of families disabled by alcohol problems amounts to many millions of dollars each year.

- Ask the participants to locate the *Alcohol and Heroin* Chart in the *Resource Manual, page* VI-3.

- State the following:

- The two types of painkilling drugs that have aroused the greatest social concern are

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narcotics (primarily heroin) and alcohol. There are both striking parallels between the substances and essential differences.

- Consider the following parallels:

1. Both substances are formed naturally.

   Alcohol is a product of fermentation, occurring in the making of wine, beer, cider, etc.

   Opium, the base for most narcotics, is obtained from a milky substance contained in the unripe seeds of the poppy plant, papaver somniferum.

2. Both can be used as a general anesthetic, because both depress the functions of the central nervous system.

   Heroin depresses respiration by its depressant action on the central nervous system, and death may result from medullary paralysis.

3. Alcohol belongs in the class with anesthetic drugs, both in its chemical composition and in its effect upon the physiology. By combining with the fatty tissues of the body as well as the brain cells, like ether or chloroform, it produces changes that are anesthetic in character.

   During the administration of an anesthetic, the individual passes through the induction stage and then into activity, when the controls are released, the same results follow ingestion of alcohol over a period of time.

   As with other anesthetic agents, there is eventually a period of unconsciousness. If an anesthetic agent is continued in administration for a period beyond safety, the vital centers of respiration and circulation can be paralyzed.

4. Both can be used regularly without addiction.

A study indicated that heroin users can use heroin two or three times per week for many years without experiencing tolerance or withdrawal. Another study indicated that there is a broad range of reactions to heroin.

NOTE: *The finding that heroin addiction is far from inevitable was confirmed in another way by psychiatrist Norman E. Zinberg and researcher Richard C. Jacobson. Through ads in the underground press and by personal contacts, they found 54 people, in their late teens to mid-fifties, whom they believed to be using heroin only occasionally. Some used heroin very irregularly, others only on special occasions, still others perhaps as often as every Saturday night. In contrast to confirmed addicts (who shoot up several times a day) these users could go without heroin for a week or more. They believed very definitely that they could become hooked, but they had not increased their frequency of use for more than a year and in most instances for several years. Many actually were decreasing their use, usually because they feared addiction or arrest.*

The White House's Special Action for Drug Abuse Prevention commissioned sociologist Lee N. Robins, of Washington University in St. Louis, to find out what became of Vietnam addicts.

Conventional programs attempting to "cure" addicts are influenced heavily by law-enforcement policies that classify addicts as criminals. Such programs seldom help more than 20 percent of their clients to stop using heroin.

Yet Robins discovered that the cure rate for a cross section of GI addicts after eight to ten months of civilian life

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was dramatically higher--better than 90 percent. Most of the ex-addicts surveyed said they knew how and where to get heroin if they wanted it. But only 8 percent of the veterans who had been addicted in Vietnam admitted they still used opiates regularly. New urine tests confirmed the abstainers' claims. Furthermore, many actual opiate users who had not been detected by the original urine tests had since left heroin behind, even without special treatment.

Millions of people drink to the point of intoxication regularly without experiencing tolerance or withdrawal.

For 1970, the projected total number of drinkers in the United States 15 years of age and over was 95 million.

If we accept reliable estimates that about nine million people in this country are alcoholic and problem drinkers, then the average drinker with no alcohol related problems actually drinks much less than the national average of 3.93 gallons of alcohol. Thus, as surveys confirm, this Nation had millions of occasional and very moderate drinkers (NIDA-HSM-42-73-77).

- The most significant differences between narcotics and alcohol include:

1. Side effects:

   Pure narcotics (opiates) are generally efficient painkillers with few destructive side effects.

   Alcohol is a far less efficient painkiller, and produces many destructive side effects.

2. Degenerative effects:

   Use of pure opiate causes little, if any, short-term or long-term degeneration of body organs and tissues.

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3. Contamination:

It is almost impossible to purchase pure narcotics on the street. Because they come via an illegal supply chain, they are usually cut with other substances many times before reaching the user.

Since opiates cannot be purchased legally, the addict is forced to purchase an uncontrolled product of dangerously variable concentration and often containing poisonous adulterants (Chein, 1964).

Because alcohol is legally produced and distributed, its purity is generally controlled.

4. Withdrawal:

Withdrawal from narcotics rarely produces convulsions or death. Normally, withdrawal from heroin takes approximately 72 hours, and produces symptoms similar to those that accompany acute influenza.

Alcohol withdrawal frequently produces both convulsions and death. Withdrawal from alcohol usually takes two or more weeks and is accompanied by more severe symptoms, notably delerium tremens (D.T.'s) and convulsions. Alcohol withdrawal must be carefully regulated by physicians.

The onset of heroin withdrawal symptoms begins six to eight hours after the last "fix." Symptoms produced are similar to a bad case of the flu: runny nose, stomach cramps, diarrhea, vomiting, muscle cramps, shaking chills or profuse sweating, "gooseflesh" skin, insomnia, and general irritability or jitteriness. The maximum severity of symptoms develops within 24 to 72 hours after the last use of heroin, with the more dramatic symptoms subsiding in five to seven days, even without treatment. More subtle withdrawal symptoms, however

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	(such as irritability and difficulty with sleeping), may last much longer. Methadone, meperdine (Demerol®), and other narcotics can produce similar withdrawal symptoms, but differ primarily in time, course, and severity (for example, methadone withdrawal symptoms are more prolonged but more mild than those of heroin withdrawal). Although the physiological basis of these withdrawal symptoms is well established and is primarily subcortical in origin, psychological factors modify to a great extent how the symptoms are perceived and interpreted.
10 minutes	• Ask the group if they have questions about the material presented thus far. If so, respond accordingly.
15 minutes	LECTURE: TENSION LEVELS • State the following: - In order for us to understand substance dependence, we need to understand the physiological aspects of substance dependence, and their relation to individual tension levels. In order to assist you in understanding what happens to an individual's tension level, there are charts in the *Resource Manual*, starting on page VI-5. - The charts are illustrations of condensed material taken from an article that appeared in the Maryland State Medical Journal, April 1970. The article was written by Dr. Stanley F. Gitlow. - Also, these charts are illustrations from a transcript of a lecture delivered (February 24-25 and October 27-28, 1966) for the Alcoholism Interagency Training Project of the Community Council of Greater New York. That state program for social workers was supported by the National Institute for

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Mental Health.

- Ask the participants to locate the chart entitled, *Reactions to Sedative-Hypnotics (Particularly Alcohol),* in the *Resource Manual*, page VI-5.
- State the following:
  - These charts will attempt to illustrate the physiological aspects of substance dependence, and their relation to individual tension levels.
  - Various reactions to consumption of sedative-hypnotics (particularly alcohol) are illustrated in the chart entitled, *Reactions to Sedative-Hypnotics (Particularly Alcohol).*
  - A normal tension range is defined by Dr. Gitlow as the mean of average tension level for adults. Chart 1 illustrates the variations in reactions to alcohol consumption from death due to absence or tension, from death due to convulsions.
- Ask the participants to turn to Chart #2, entitled, *Average Tension Level.*
- State the following:
  - This chart indicates that tension levels increase and decrease due to daily events, varying with each individual. The average tension level (ATL) constitutes a range of tensions that the individual experiences, unaltered by the influence of substances (drugs).
- Ask the participants to turn to Chart #3, entitled, *Tension Changes Due to Alcohol Consumption.*
- State the following:
  - When alcohol is ingested it depresses the brain, and it diminishes the psychomotor activity level. The psychomotor activity level may be measured by the amount of anxiety of tension noted.

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	- Diminished psychomotor activity level means relief from anxiety and whatever it is that may bother the individual: insomnia, tension job, or family pressures. - When the person's blood alcohol rises, his psychomotor activity level goes down; he is relieved, relaxed, less anxious, less frightened, less worried than before. - But as soon as the blood alcohol level starts to fall, this sedative effect diminishes, and even a big dose, such as a couple of jiggers, wears off very rapidly after the second hour. - If that were all, there is a distinct possibility that we might not have the disease called alcoholism, because under those circumstances, an individual could drink to get relief, his anxiety level would diminish, the drink would wear off, and he would come back to where he was before. But there is another effect that acts in the opposite direction. - The second effect is to increase the psychomotor activity level. This increase takes place immediately after taking a drink, but is not immediately felt because the change is less intense than the sedative effect. This (latter) lasts two or three hours, while the opposite or agitating effect usually lasts for about 12 hours after one big drink. - Therefore, as the short-term sedative effect wears off, the other effect of alcohol--increased psychomotor activity--becomes apparent. No one in this world can get a sedative effect from any known drug without it being followed by an agitating effect which wears off more slowly (Gitlow, 1970). - The first effect of reduced tension level resulting from sedative hypnotic consumption is illustrated in Chart 3: *Tension Changes Due to Alcohol Consumption* (see notation S^1).

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- The second effect on an increase in tension level is illustrated in Chart 3, notation S^2.

Ask the participants to turn to Chart #4, entitled, *The Build-Up Effects of Additional Alcohol Consumption.*

State the following:

- Near the end of the second hour after the original drink, when the sedative effect wears off and the agitating effect starts to gather momentum, the individual is more tense than he was before he drank at all.
- And so he will have another drink and the anxiety level will diminish again, but in about two hours, the psychomotor activity level will rise again, higher than ever.
- This cycle of increased tension, drinking, short-term sedative effect, longer-term agitating effect, higher tension, drinking again, can go on for some time.
- Eventually, however, a point is reached when decreasing the psychomotor activity level to a really low state is difficult, no matter how much alcohol is taken. This is because the agitating effects from all of the previous drinks are cumulative.
- This effect is illustrated in Chart #4, entitled, *The Build-Up Effects of Additional Alcohol Consumption.* Look at the anxious-aggressive level and the reduced inhibition level.
- This agitating effect occurs in experimental animals and in humans; it is inherent in the pharmacology of the drug. You don't have to be an alcoholic in order to experience it. Anyone gets this effect if he drinks enough.

- Ask the participants to turn to Chart #5, entitled, *Hair-of-the-Dog Effect.*
- State the following:

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- After an evening of heavy social drinking, you may have a hangover, the common name given to this condition of after-agitation. A drink (hair-of-the-dog) will relieve this because it provides sedation to counteract the agitation of last night's drinking.
- Of course, the morning drink is going to be followed by its own agitation for another 12 hours, but the drink may get you through a trying period until you begin to get a decrease in the agitating effects of the heavy drinking from the night before.
- This effect is illustrated in Chart #5, entitled, *Hair-of-the-Dog Effect*. Look at the Hangover, Anxious, and ATL levels.

• Ask participants to turn to Chart #6, entitled, *Effects of Higher Alcohol Dosages*.

• State the following:
  - This chart indicates the effects of higher dosages of alcohol. Look at the loss of coordination control at five to seven hours of drinking and how long it takes to get back to a normal state or level of psychomotor activity.
  - If, however, an individual has been drinking heavily over a long period of time it may take many days for his psychomotor activity level to return to its normal state (Gitlow, 1970).

• Ask participants to turn to Chart #7, entitled, *Tension Levels Produced by Forty Eight Hours of High Level Alcohol Consumption*.

• State the following:
  - This chart indicates the tension levels produced by 48 hours of high level alcohol consumption. Look at the delerium tremens level.
  - The charts emphasize the relationship between sedative-hypnotics (particularly

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	alcohol) and tension levels. The charts establish a physiological basis for the effects in a normal life situation. Please remember that even though alcohol was utilized to illustrate the effect of depressants, Chart #1 can be used to illustrate other substance use, such as stimulants. - I would like to illustrate the reality of tension level effects in life situations through the use of a cartoon character named "Stan Abuse." ● Ask the participants to locate in the *Resource Manual*, page VI-19, a comic strip entitled, "Stan Abuse."
10 minutes	● Read aloud the following: Let us imagine a man--call him "Stan Abuse" --who is 34 years old, married, has children, and is employed in a middle-level management position. He is comfortable, but motivated to advance in his career. On a Friday afternoon, he stops after work for a drink with some friends. After a couple of drinks, he excuses himself and goes home to shower and get ready to go out to dinner with his wife. He has a quick drink before leaving for the restaurant... ● TURN THE PAGE. Where he and his wife wait 30 minutes in the cocktail lounge. A round of drinks is served. The food is excellent. Stan and his wife enjoy a good wine with dinner, and order a fine liqueur to top off the meal. ● TURN THE PAGE. They visit a night club and have a few more drinks. Our friend becomes quite merry, and the couple stops off at a friend's place for

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a nightcap. It's O.K., because it's Friday and Stan knows he can sleep late on Saturday morning.

TURN THE PAGE.

But what actually happens on Saturday morning?

Our previous discussion of physiological facts suggests that, becuase the subject of our story drank over an eight-hour period, he may indeed sleep peacefully for a while.

But his tension level will gradually rise throughout the early morning hours, until it passes the normal level. By about 7 a.m., Stan's tension level will be high enough so that footsteps on the stairway or a door slamming anywhere in the house will wake him.

For the next 36 to 48 hours, his tension level will continue to be higher than normal. If he doesn't drink anything more he should reach a normal tension level by early Monday morning.

Because he is unable to sleep, he decides to get up. His head is aching and he feels bad. Never mind, a Bloody Mary will fix that. Now he's up and about and feeling better. He gets hot and dusty doing yard work, so he has a beer or two to quench his thirst.

TURN THE PAGE.

Then a neighbor drops in; that calls for ham sandwiches and another beer.

Saturday evening a friend stops by, so drinks are served to show the host's hospitality. Stan finishes off the night with a beer while, watching television.

Saturday's alcohol, when added to Friday's alcohol, means that it will be late Tuesday before Stan's tension level becomes normal.

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- TURN THE PAGE.

Sunday, Mr. Abuse spends a quiet day on the lake with the family, so he only drinks a six-pack of beer. By Sunday night, he is doomed to suffer serious after-effects until Wednesday afternoon. And he only got high once.

TURN THE PAGE.

When he wakes up Monday morning, Stan's tension level is elevated well above normal, but it is not yet high enough for him to notice. A typical American, the first thing he does is drink a cup of coffee to get started. He will probably have another cup before he leaves home, and still another cup of coffee every 90 minutes for the rest of the day.* The caffeine increases the stress on Stan's system and temporarily elevates the activity level.

Once he is up and dressed, the subject joins the flow of commuter traffic, thereby adding more stress and tension to those produced by the coffee and alcohol.

Having reached his office, Mr. Abuse will wrestle with the volume of work typical of the first of the week. He takes three or four coffee breaks, attends a staff meeting, and participates in another commuter rush at 5:00 p.m.

By 5:30, his tension level is high. He feels like taking off his shoes, having a drink, and relaxing. Possibly he will have a beer or two during the evening.

Stan repeats Monday's pattern all week. When Friday comes again, he is already going to experience an increased level of tension through Sunday afternoon.

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*The average cup of coffee contains about one to one and one-half grains of caffeine--a stimulant primarily affecting the heart and nervous system.

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	Add another weekend of increased alcohol consumption, then another typical week, and the subject has acquired from a week to ten day's elevated tension, resulting from the aftereffects of drinking. If nothing changes, this tensions' level will remain more or less constant throughout the rest of his adult life. At this point in Stan's life, the increased tension level is present, but not very apparent. As long as his home life remains happy, work goes well, and his health is excellent, the tension patterns may not become significant. But suppose something goes wrong? TURN THE PAGE. If a day comes when his sales slip and he becomes irritable at home due to pressures from work, problems will begin to develop. One Monday, as pressure mounts, Stan might be chastized at a staff meeting because of his poor sales performance. He returns to his desk to work on his reports, but finds that he can't concentrate. He gets a cup of coffee and again tries to concentrate, but he feels **too** anxious to work. He decides to make a few contacts but that doesn't go well because he is too tense. He considers going home but there's tension there, too. He finally drops by a bar for a few drinks and then goes home. TURN THE PAGE. The next day Stan arrives at work determined to improve his performance. But yesterday's drinks, coupled with the residual tension, make that impossible. The ensuing frustration may result in his having a drink at lunch, and a few more

in the evening.

At this point, what Stan Abuse really needs is to spend several days without any drinking, so his tension level can drop to a more reasonable level. He also needs to cut back on his caffeine consumption; that would also help him relax.

Instead, since he has no understanding of the cycle in which he is caught, he perpetuates it.

He finally decides to visit a busy doctor in a nearby office. Stan explains that circumstances temporarily combined to produce increased tension and pressure at work. He convinces the doctor that he is suffering from tension and anxiety--a minor, temporary incapacitation.

- TURN THE PAGE.

The doctor decides to prescribe a minor tranquilizer. When the patient hears the word minor he assumes that it means small or insignificant. This seems just the right remedy for a not-too-serious problem.

The word "minor" as used by the doctor doesn't mean "minor" as the patient understands it. In the case of tranquilizers, "minor" means that the tranquilizer won't destroy all of the patient's muscle control. It will reduce tension and anxiety, but will leave the patient functional.

NOTE: *The term "minor tranquilizer," although commonly applied, has contributed to the misunderstanding. Drs. Klein and Davis, in* Diagnosis and Drug Treatment of Psychiatric Disorders, *state:*

> *The irretrievably ingrained term "minor tranquilizer" is most unfortunate for it implies that these agents act like major tranquilizers but to a lesser degree; one might expect large doses of the minor.*

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> *tranquilizers to have approximately the same clinical effect as small doses of the major tranquilizers and to be effective in the same range of clinical conditions. Actually, this is not the case; the minor tranquilizers more closely resemble sedative hypnotic drugs such as the benzodiazepines than major tranquilizers such as the phenothiazines.*
>
> *The phrase "minor tranquilizer" is a medical term the doctor shouldn't share with his patient unless he carefully explains its meaning.*

The physician should have said:

"I'm about to prescribe to you one of the most difficult-to-manage medications known to us; it produces, as an aftereffect, exactly the problem I am giving it to you to relieve.

"If we are not careful, you will join the millions of other persons on this medication who are given prescriptions to counteract the effects of previous prescriptions. I can only give you this medication if you discontinue all use of alcohol, stop using caffeine, and alter your work regime and life style to reduce the real sources of tension. Then, if you don't improve in the next two or three weeks, we'll have to take you off this medication and try something else."

But usually the patient receives neither the clear information nor the careful warning that is in order. Without this essential lecture, the patient will get up the next morning and take the tranquilizer, believing it will reduce his tension level.

Indeed, for six to eight hours, the tranquilizer will work effectively. When tension again begins to increase around 4:00 p.m., patient Stan Abuse will, as usual, have martinis to help him unwind.

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	These will get him through until about 1 or 2 a.m., when again he will pass through the normal tension range, approaching the increased tension zone. The next morning, he will wake up more tense than before because of the secondary effects of yesterday's relaxation-by-drinking. So he takes more medication. Soon Stan begins reaching his increased tension zone at about 1 or 2 a.m. He wakes up and has insomnia for three or four hours. He returns to his doctor and demands to know what is happening: "I feel good all day because of the medication you gave me," he says, "but I can't sleep at night. If the doctor says, "That's all right, I'll give you a barbiturate to get you to sleep," the cycle is complete. Now at about 10 p.m., when his martinis are wearing off and the aftereffects of his tranquilizers are starting to boost his tension, Stan will take a barbiturate to make himself sleep. This won't wear off until about 7 a.m., at which time his tension level is again rising. The tranquilizer he took is producing more tension. The alcohol he drank is producing more tension. The coffee he drank to help him wake up is producing more tension. Now he is really tense and **needs** his tranquilizer more than ever. This story illustrates a tragic and unnecessary life pattern common to millions of Americans.
10 minutes	● Ask the group if they have any questions about the material presented thus far. If so, respond accordingly. ● State the following:

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	- People using sedative-hypnotics should abstain from all such drugs long enough to be free from all their effects for a period of time. They should attempt to reach the point where they can find out how much tension is real and requires treatment, and how much is simply the aftereffect of substance use. - In this module, some of the unique properties of sedative-hypnotics that contribute to unnecessary dependency on those drugs have been discussed. These are other characteristics that probably should be covered, but many of those have been reviewed thoroughly in other works. - The facts highlighted here have come to light only recently. They have caused problems even when many of the social, psychological, and cultural patterns commonly associated with drug dependence are not clearly present.
15 minutes	BREAK
10 minutes	LECTURE: TREATMENT OF SUBSTANCE DEPENDENCE: AN OVERVIEW ● State the following: - Virtually all forms of individual therapy have been tried in the treatment of chemical dependency. - During the 19th century, treatment for drug abusers was generally handled by private physicians and usually involved simply helping the patient through withdrawal. - The widespread medical use of morphine for relief of pain during the Civil War resulted in morphine addicition among thousands of soldiers. Many of these "medical addicts" were withdrawn successfully from morphine when it was no longer needed for pain relief, but many others continued compulsive use of the drug.

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	- The easy availability of opium in the form of patent medicines resulted in addiction among thousands of other people--many of them rural housewives. - Heroin, a semisynthetic derivative of morphine, was developed in 1898 as a potent pain-killer and cough suppressant, and was believed to be nonaddictive. Because heroin relieved morphine withdrawal symptoms, it was advertised as a cure for morphine addiction. Several years passed before medical authorities discovered that heroin was as addictive as morphine. - In the late 1800s most physicians regarded drug addiction as a physical disease which could be cured by gradually reducing use of the drug (withdrawal). - The psychological element of addiction was ignored largely and, because there was very little follow-up on patients after treatment, the significance of the problem of relapse was not recognized. - The problem of drug addiction did not become a public health issue until the early years of the 20th century when the public became increasingly aware of the link between narcotics and organized crime, as well as the growing incidence of drug addiction among physicians. - The Harrison Act, passed in 1914, restricted the distribution of opiates and cocaine to registered physicians and dentists for use only in the course of professional practice. - The Federal Government interpreted the law as prohibiting doctors from prescribing maintenance doses to addicts, and as a result numerous indictments were brought against honest physicians who believed that maintenance was the only useful treatment for dependence, as well as the notorious "script" doctors who indiscriminately prescribed large doses of opiates. - After 1919, when legitimate sources of narcotics were no longer available, thousands of addicts, particularly those in the larger cities, turned to the illegal market.

- To deal with this new problem, the Federal government encouraged large cities to establish temporary clinics for maintenance of dependent persons on doses of opiates with the idea of gradually reducing the dosage and eventually withdrawing the drug.

- Of the 44 clinics which were established, some claimed success in gradually withdrawing patients, others merely provided maintenance, and several became notoriously careless in their distribution of opiates.

- The poor performance of some of the clinics along with the condemnation of outpatient maintenance by the American Medical Association led the Federal government to withdraw its support.

- The last of the clinics had closed by 1925.

- In the following few years, the emphasis on prohibition appeared to solve part of the problem of drug abuse, particularly the danger of medical dependence which had resulted from prescribed drugs and patent medicines.

- However, a new pattern of drug abuse had begun to emerge in the larger cities.

- The declining population of mostly middle-aged medical dependents was beginning to be replaced by a new group of young male users who preferred heroin to morphine.

- From 1925 to 1935, treatment for drug abusers was virtually nonexistent.

- By that time the medical community was well aware of the extremely high relapse rate among chronic users, and a mood of discouragement prevailed.

- Because the Federal prisons were receiving large numbers of drug addicts, in 1929 Congress authorized the establishment of two drug abuse treatment hospitals, primarily as a means of segregating the opiate-dependents from other prisoners.

- The first Federal drug abuse treatment clinic opened in Lexington, Kentucky, in 1935; the second opened in Fort Worth, Texas, three years later.

- Although the clinics were designed primarily for incarceration of Federal prisoners who were drug addicts, voluntary patients were accepted, and soon made up the majority of patients.

- The clinics withdrew patients using decreasing doses of morphine, followed by a period of inpatient treatment which was supposed to last several months.

- Voluntary patients were free to leave whenever they wished, however, and most of them did not stay to complete the full treatment period.

Follow-up studies showed that a substantial majority of those patients relapsed to drug use.

The Federal clinics at Lexington and Fort Worth were the only major drug abuse treatment facilities in the country until 1952, when the State of New York opened Riverside Hospital for juveniles in response to the alarming increase in drug addiction among teenagers in New York City. Treatment involved hospitalization for a period of 18 months or more, followed by a period of outpatient care. Because the hospital had actual custody of the juveniles for up to 3 years, most of the patients completed the full treatment regime. Several years later, however, a study showed that approximately 95 percent of the patients relapsed after treatment, and Riverside was closed in 1963.

The explosion of drug addiction in the urban slums in the 1950s and 1960s led to a search for more effective treatment methods. Synanon, founded in 1959 by a former alcoholic named Charles Dederich, was the first of a line of residential treatment programs called therapeutic communities.

- These programs emphasized the psychological element of drug addiction and attempted to modify the addict's character through group therapy and reinforcement of good behavior. The communities were not designed to treat large numbers of people at one time, and many who entered the programs dropped out after a short period.

- However, the novelty of the method and the dramatic success of the few who remained in the communities attracted the attention of the public.

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The therapeutic community and group therapy were soon recognized as important methods of treatment.

- In 1961 and 1962, California and New York established statewide treatment programs for drug addicts. The programs were modeled after Lexington, but were expected to be more successful because aftercare was compulsory. Treatment involved withdrawal, psychiatric care, and group therapy--beginning with a period of mandatory hospitalization. After several years, the results of both programs were disappointing. As in the case of Lexington and Riverside, the programs were believed to have very high patient relapse rates.

In 1964, Marie Nyswander and Vincent Dole began an experimental drug maintenance program in New York using methadone, a synthetic opiate substance. Hospitalized patients were gradually stabilized on a high daily dose of methadone. After stabilization, the patients were released and required to return to the clinic daily for their methadone dose. They also received individualized counseling and support services. All the patients stayed in the program voluntarily, and most showed dramatic improvements in social functioning, in terms of employment or enrollment in school.

- Encouraged by this success, Doctors Dole and Nyswander expanded the program and enrolled about 4,000 patients over the next three years. In 1967, an independent evaluation of the program showed that 80 percent of the patients had remained in the program and showed significant improvements in social functioning.

- The Federal government then permitted the establishment of other experimental methadone maintenance programs. Subsequent experiments showed that initial hospitalization was unnecessary, a factor that reduced greatly the expense of the programs. Methadone programs then proliferated across the country, and by 1972 methadone had become one of the most widely used treatment methods.

- At about the same time that methadone experimental programs were beginning in 1965, researchers at Lexington began to experiment with the use of narcotic antagonists--drugs that counteract the effects of opiates without being addictive themselves. The antagonists had already clinically proved to be useful in treating cases of narcotic overdose and in detecting opiate-dependent individuals. The main problems with using antagonists in the treatment of addiction proved to be their short duration of action and some unpleasant side effects, which discouraged, rather than encouraged, addicts to continue in treatment.

- In 1966, while methadone maintenance was still in the experimental stages, the Narcotic Addict Rehabilitation Act (NARA) (P.L. 89-793) was passed by Congress.

Title I of the Act authorized diversion to treatment before conviction for a restricted class of Federal offenders.

Title II provided for treatment as a sentencing alternative for a slightly higher class.

Title III provided for voluntary and involuntary civil commitment to Federal treatment facilities in localities where no adequate State treatment facilities existed.

Title I of NARA has been little used, apparently because of a lack of interest by U.S. District Attorneys and the restrictions on eligibility.

Title II has been used to a greater extent, but strict eligibility standards also prohibited its widespread use. However, as a result of Title II, the Bureau of Prisons has initiated a number of innovative treatment programs for a wider variety of drug-dependent offenders.

Title III served primarily as a mechanism through which the Federal treatment facilities were made available to States and local communities where no adequate facilities existed.

In terms of current funding priorities, Title IV was the most important part of the Narcotic Addict Rehabilitation Act. Under Title IV, the Federal government began to provide financial and technical assistance to States and cities for the development of drug abuse treatment programs.

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	- Two other pieces of Federal legislation authorizing additional aid to State and local treatment programs followed during the next five years. - The Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513) further expanded community assistance programs to include all types of drug-dependent persons and drug abusers as well as opiate-dependents. In addition to providing financial support for community-based treatment programs, in recent years the Federal government has encouraged development of programs that offer more than one method of treatment, referred to as *multi-modality programs*. - The Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) provided greatly increased Federal resources to develop community-based, multi-modality treatment centers throughout the United States. - The Federal government has also encouraged treatment programs to judge patient "success" by more flexible standards. In the past, total abstinence from drugs was regarded as the only criterion of success in treatment. Today, however, reduced drug use along with improved social functioning is regarded as a degree of success. - The fact remains that no treatment method yet developed has solved, or promises to solve, all of the complex problems involved in drug abuse. There is still confusion and controversy about the nature of drug dependence and how society should deal with it. It is clear, however, that a variety of methods and approaches must be available to help the various types of drug abusers that exist today.
10 minutes	● Ask the group if they have any questions about the material presented thus far. If so, respond accordingly.

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10 minutes

LECTURE: PRESENT METHODS OF TREATMENT: AN OVERVIEW

- State the following:

1. Hospitalization

   - Hospitalization was used to treat drug dependents in the 19th century, and the method was continued at the Lexington and Fort Worth clinics established in the 1930s.

   - Treatment began with gradual withdrawal of the drug, by decreasing the dosage over a period of one or two weeks, until the patient was drug free.

   - Withdrawal was followed by a period of inpatient care, usually lasting several months, during which the patient remained isolated from his former environment and from drugs, and received psychiatric counseling, psychotherapy, group therapy or work therapy.

   - The third stage of the hospitalization method consisted of a period of outpatient aftercare in which the patient lived in his community but continued to receive counseling, psychotherapy or vocational rehabilitation.

   - The California and New York State treatment programs and the Federal NARA program, started in the 1960s, used the Lexington model of hospitalization, although they tried to improve it. The precise degree of success or failure of these hospitalization programs is debatable, because follow-up studies had difficulties with data collection and definition of "success" or "failure" of treatment. Despite the fact that a mental health approach and professional therapy were used, the emphasis on security and isolation of the patients from the community resulted in a prison-like atmosphere in many of the facilities.

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- The term "civil commitment" has often been used to describe the hospitalization meth method because legal controls have been used frequently to confine patients to hospitals.

- Hospitalization is the most expensive method of treatment, and today it is generally believed to be the least effective method, in view of the high relapse rates of most hospitalization programs over the years.

- For these reasons the Fort Worth clinic has been closed; Lexington is now closed to patients--except those participating in research; and the NARA hospitalization programs presently are being phased out.

2. Methadone Maintenance

- In recent years, methadone maintenance has been the most widely used method for treating opiate-dependent persons. Most large cities have treatment programs that provide methadone detoxification and maintenance services after a diagnosis of opiate addiction has been made.

- Methadone maintenance programs have demonstrated the ability to attract and retain in treatment a large number of opiate-dependent persons. In addition, since most methadone maintenance programs offer treatment on an outpatient basis, it is a markedly less expensive method than treatment which involves hospitalization or confinement.

- The methadone maintenance technique developed by Dole and Nyswander used methadone in sufficient dosage to create in patients a "blockade effect." In other words, with this technique, patients became tolerant to the euphoric effects of opiates.

- For example, if a patient used heroin while receiving daily a large oral dose of methadone, he would not experience the

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usual euphoria that accompanies heroin usage.

- In many patients this "blockade effect" tended to discourage repeated illicit opiate usage. During the last ten years, however, many investigators have reported similar successful treatment outcomes for patients using smaller daily doses of methadone. This method has a particular advantage in that the patient is less dependent on opiates. For this reason many maintenance programs today use a lower daily dose of methadone, which is sufficient to prevent withdrawal symptoms, although it does not completely "block" the effects of a sufficiently high dose of heroin.

- Federal regulations now require that methadone maintenance programs provide additional treatment such as group therapy, family counseling, vocational training, and social services.

- Eligibility is limited to persons 16 years of age or older who can demonstrate that they are opiate-dependent and have been for at least two years. Persons between the ages of 16 and 18 must have parental consent and must have tried and failed at least two attempts at detoxification.

- Although the ultimate goal of methadone maintenance treatment is eventual withdrawal from methadone and elimination of dependence on any drug, for some individuals maintenance may continue for months or years.

- The general theory behind methadone maintenance is to relieve the craving for heroin while engaging the patient in additional treatment aimed at helping him work out a better way of living.

- In addition to maintenance, methadone programs also provide outpatient detoxification. This treatment involves

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administering decreasing doses of methadone over a period ranging from a few days to a few weeks for the purpose of relieving withdrawal symptoms.

- Some addicts volunteer for detoxification in an attempt to become drug-free. However, statistics reveal that detoxification alone is usually unsuccessful. Most patients either relapse to heroin use or enter methadone maintenance programs after detoxification has failed.
- Critics of the methadone maintenance method point to the fact that methadone does not cure drug dependence but merely transfers dependence from one drug to another.
- Another criticism is that some patients begin chronic abuse of other drugs such as alcohol, amphetamines, barbiturates, or cocaine while enrolled in methadone maintenance treatment.
- In view of these deficiencies, current Federal policy emphasizes that entry into methadone maintenance should be voluntary and that drug-free treatment should be offered as an alternative.

3. Therapeutic Communities

- Therapeutic communities are residential treatment programs which attempt to deal with the psychological causes of addiction by changing the addict's character and personality.
- The first therapeutic community for drug addicts was Synanon, founded in 1959. The techniques used were modeled after those of Alcoholics Anonymous, which involved repeated confessions, group interaction, and mutual support among the members. During the late 1950s and early 1960s, the concept of group therapy was growing in popularity throughout the country, and as therapeutic communities developed they adopted it as a major technique.

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	- The growth of therapeutic communities also paralleled the growth of communes, and some of the cooperative spirit of the communes was incorporated into the therapeutic communities. The idea of a group of people living and working together for their mutual benefit was, and still is, a basic tenet of the therapeutic community. - Although therapeutic communities are often managed by former addicts, and do not usually have mental health professionals on their staffs, the treatment method is based on two techniques of group psychotherapy. - The first technique is confrontation, or encounter group therapy, in which the addict is forced to confess and acknowledge his weakness and immaturity. - The second technique is "milieu therapy" in which the addict lives and works within a hierarchial social structure and may progress upward in status as he demonstrates increased responsibility and self-discipline. - The principles of behavior modification, or conditioning, are applied constantly within the community in the form of reinforcement of good behavior and punishment of bad behavior. - The time period for treatment varies from one therapeutic community to another. Syanon is a permanent community where residents may remain for life. Most therapeutic communities require members to stay one or two years. - The programs also vary in selectivity. The older programs screened applicants rigorously, accepting only the most highly motivated individuals. - The older programs also continue to be completely drug-free, whereas some of the newer programs use methadone maintenance

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or both methadone and drug-free therapy.

- The problem with therapeutic communities as a treatment method is that they appear to be suitable for very few people. In fact, about 75 percent of those who enter them drop out within the first month. Members who remain in the communities and seem to respond to the treatment regimen are largely white and from middle-class backgrounds.
- Some critics feel that the treatment of residents in a demeaning or punitive way, which is characteristic of many communities, goes against the principles of supportive psychotherapy.
- Because they are residential, therapeutic communities are more expensive to operate than drug-free outpatient programs, even though many are operated entirely by members. In terms of results, however, therapeutic communities do not appear to be more effective than other drug-free methods of treatment.

4. Drug-Free Outpatient Treatment

The treatment method that offers drug-free services on an entirely outpatient basis is referred to as either drug-free outpatient, ambulatory drug-free, or outpatient abstinence treatment.

- There are many differences among programs as to the scope or level of treatment they provide, but they usually include some or all of the following services:

- group or individual psychotherapy,
- vocational and social counseling,
- family counseling,
- vocational training,
- education,
- community outreach.

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- Programs also differ in the degree of patient involvement in treatment. Some programs are social or "rap" centers where patients drop in occasionally. Others are free clinics providing a range of health services. Some programs provide structured methadone detoxification and monitor patient drug use by urine analysis throughout treatment.

- Little evaluation has been done on this method of treatment since program records often omit data on patients who drop out of treatment early. Most experts believe that these programs do help some people but that the attrition rates are very high.

- It appears that drug-free outpatient treatment may be more effective with youths who are experimenting with drugs than it is with hardcore addicts.

5. Multi-Modality Treatment

- In recent years some treatment programs have adopted a multi-modality approach by providing more than one method of treatment. This approach has the advantage of offering the patient a choice among alternative treatment regimens. Some patients respond better to a particular method of treatment than to others, and in a multi-modality program patients may be transferred easily from one type of treatment to another.

- This approach allows for more choice by patients.

- The larger multi-modality programs may include methadone maintenance, detoxification services, inpatient and outpatient drug-free treatment, and a therapeutic community. The Federal government today gives strong support to community-based multi-modality approaches to drug dependence treatment.

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5 minutes	Ask group members if they have questions about the material presented thus far. If so, respond accordingly.
5 minutes	LECTURE: TREATMENT FOR NONOPIATE DRUG DEPENDENCE ● State the following: 1. Treatment for Nonopiate Drug Dependence - At the present time, there are no specialized methods for treating dependence on drugs other than opiates or alcohol. There is no chemotherapy, such as methadone maintenance, for treating abuse of the nonopiate drugs which include amphetamines, barbiturates, and hallucinogens. - These drugs are often referred to as "soft drugs" as opposed to "hard drugs" (opiates). - This term is often misleading in that it implies that these drugs are less harmful. In fact, they are often equally as addictive as hard drugs and in some cases more life threatening. - For example, abrupt withdrawal from barbiturates is much more life threatening than withdrawal from opiates; for that reason, withdrawal from barbiturates requires hospitalization. - Simultaneous use of more than one drug sometimes produces serious adverse reactions, including accidental (or intended) overdose. People who abuse two or more drugs, either simultaneously or alternately, are often referred to as polydrug abusers. - Emergency treatment, usually called crisis intervention, is sometimes required for acute adverse reactions resulting from nonopiate drug use. - For example, adverse effects of amphetamines and hallucinogens sometimes result

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paranoid or violent behavior. Hospital emergency rooms can provide treatment in such emergencies, as well as in overdose cases.

- However, during the late 1960s when soft drug use was spreading rapidly, many young drug users were reluctant to go to hospitals, fearing trouble with the authorities or the hospital environment itself.

- As a result, free clinics were set up in many cities to provide an alternative to emergency room treatment. Since 1967 when the Haight-Ashbury Free Clinic opened in San Francisco, more than 250 free clinics have been established across the country.

- Staffed by doctors, psychologists and others on a volunteer basis, these clinics provide a variety of general medical and social services in addition to treatment of drug abuse emergencies. For those experiencing adverse psychological reactions to drugs, these centers provide a variety of general medical and social services in addition to treatment of drug abuse emergencies. For those experiencing adverse psychological reactions to drugs, these centers provide a calm, supportive environment and reassurance, or "talking down," by an experienced staff member.

- In addition, many crisis intervention programs operate telephone hotline services which provide information, referrals, and counseling on request.

- Most crisis clinics have very little follow-up on patients, since they are primarily concerned with immediate problems. Many of the patients treated are young people experimenting with drugs rather than chronic, heavy users. It is generally believed that crisis centers have little lasting impact on those who are compulsive drug users.

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- In recent years, some centers have begun to offer long-term psychotherapy, as well as emergency services, in an attempt to alleviate underlying psychological problems associated with chronic drug use. Some of the larger programs now serve as community mental health centers, providing counseling and therapy for a broader range of social and psychological problems.

2. Other Treatment Approaches

   - Over the past decade a considerable amount of research effort has been focused on a class of drugs known as narcotic antagonists.

   - These drugs counteract the effects of opiate drugs in the body, including the euphoria, or "high," but unlike methadone, they do not cause physical dependence. This ability to reverse the effects of opiates has made them useful in treating narcotic overdoses.

   - Research is being conducted on the use of narcotic antagonists in helping addicts to remain abstinent after withdrawal.

   - One problem is that some antagonists have unpleasant or possibly harmful side effects

   - Another problem is that all of them are relatively short-acting, and must be administered daily. For these reasons. participation in a treatment program using antagonists requires a high degree of motivation.

   - Scientists are attempting to develop a longer-acting antagonist which would be effective for several days or weeks. It is possible that such an antagonist could be very useful in helping the addict who has been rehabilitated while on methadone and is motivated to be detoxified and remain drug-free.

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	- Because no one method of treatment has proved to be the answer to the drug abuse problem, research and experimentation are being conducted on a wide variety of potential treatment methods. - Some researchers are working with behavioral techniques such as aversive therapy, or negative conditioning, in which electric shocks or nausea-producing substances are administered simultaneously with narcotics. - Others are using biofeedback techniques to attempt to train people to control internal states and body processes. - Transcendental meditation has been investigated as a possible method of reducing soft drug use, particularly among college students. - Much attention is currently directed toward developing alternatives to drug abuse, which may include any meaningful activity or pursuits in which young people can become involved instead of resorting to drugs.
5 minutes	● Ask the group if they have questions about the material presented thus far. STOP

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1 hour

LECTURE: DRUG ABUSE TREATMENT MODALITIES: AN OVERVIEW

NOTE: Be sure that you have the following outlined on newsprint.

- State the following:

- Virtually all forms of therapy have been tried in the treatment of chemical dependency. These range from "no treatment" to "high risk group treatment activities." Despite the distinctions that I am going to make between the various types of treatment services, you should understand that these services do, in fact, form somewhat of a continuum, and that the descriptions should be looked upon as benchmarks or guidelines rather than as definitive requirements. As a consequence, whenever possible, the clients' individual strengths and weaknesses, and other factors pertinent to recovery should always be considered.

DRUG ABUSE TREATMENT MODALITIES

- The types of drug treatment modalities are as follows:

1. No Treatment Required

- The selection of this alternative assumes that the client is able to deal effectively with his environment and that drug use does not jeopardize his well-being or ability to function. If it is determined that a client needs no treatment, this information should be communicated in a supportive manner so that the client will not feel neglected because his problem isn't serious enough. The client should be encouraged to work on other areas of his life that may need improvement.

2. Drug Information and Education

- Drug information and/or education programs provide information about drugs and their effects through literature, discussion groups, films, etc.

- Such programs assume that knowledge about drugs will deter drug use, impede the escalation of drug misuse, and enable clients to make well-informed rational choices.

- These services should provide accurate information that avoids sensationalism and moralizing.

- Some "street" information programs provide additional services, such as crisis intervention, drug chemical analysis, and timely information about "unsafe" drugs being distributed in the community.

- Many drug education programs also offer clients an opportunity to examine and clarify their values and attitudes and to learn problem-solving and decision-making skills. The assumption, of course, is that these skills and techniques can be applied by the client to other areas of his life and will carry over to subsequent decisions that may confront him.

3. "Alternatives" Programs

- Typically, services in this category are not designed to deal specifically with drug abuse problems. Instead, they provide various types of individual and/or group involvements that meet many of the same needs that often underlie adolescent drug abuse. While there are a great number of services in this general category, three important subcategories can be distinguished:

  - activities directed toward achieving altered states of consciousness;

  - activities that present real and/or simulated risk situations:

  - activities that focus overtly on personal growth.

  Let us look at each type in more detail.

A. Programs or services that are directed toward helping the client achieve altered states of consciousness generally attempt to create an "inner peace" or tranquility for the participant. Activities such as yoga, transcendental meditation, bio-feedback, and self-hypnosis all focus on lessening the turmoil in the client's life, thus enabling him to manage his life with increasing effectiveness.

B. Many programs offer rugged physical activities--mountaineering, wilderness survival, parachuting--that offer an element of danger and present real, physical challenges. Such activities recognize the genuine need for risk-taking that often contributes to drug abuse.

C. A third type of service in the alternatives category is the informal group whose goal is to enhance personal growth. Participants meet on a regular basis--generally, at least once a week--to discuss what is happening in their lives. The groups are growth-oriented, aiming at the improvement of insights about self, relationships, and society, rather than toward therapeutic behavior change.

- Activities programs generally do not fall into a daily routine, are totally voluntary, require relatively little time commitment, and are only loosely organized. Such programs are appropriate for clients who might wish to grow intellectually and who are ideologically attuned to these types of activities.

- Clients coming from cultural or ethnic groups other than white, middle class may have problems identifying with or accepting the usefulness of these services.

4. Community Activities

- Programs in this category are also relatively unrelated to the specific problems of drug abuse. However, they can be thought of as preventive strategies that impede further drug involvement.

- These programs offer many diverse activities--varied sports, games such as chess, checkers, or cards, tutoring, community self-help projects, and political involvement. This diversity provides an opportunity for participants to develop a variety of skills and competencies.

- Programs of this type often depend upon volunteer support from those involved, and attempt to promote commitment and mutual concern.

- Participation is usually totally voluntary, and the time involved is generally determined by the participant's personal commitment. These factors combine to promote a sense of belonging for those clients capable of group involvement and close peer relationships.

5. Brief Counseling

- This service is typically provided by "storefront" programs where counseling assistance is provided on request.

- For the most part, such counseling focuses on immediate crises rather than long-term behavioral problems.

- Since participants are often transient, counseling services generally deal with how the client is experiencing himself and his environment at the present time. Situational problems (educational, vocational decision-making, interpersonal conflicts, drug and alcohol abuse, etc.) are dealt with on a "here and now" basis. An informal and relaxed atmosphere is maintained generally, and clients are encouraged to "drop in" whenever they wish.

- Some characteristics of programs offering these services are: long hours; an extremely relaxed, non-questioning atmosphere; an environment conducive to "hanging out"; and as little distinction as possible between staff and clients (dress, manner, etc.). The assumption is that a relaxed atmosphere and flexibility of services will encourage clients to use the program.

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	- These programs may also provide additional services described already, such as drug information and education, "alternative" growth programs, and involvement in community activities. - The participant's commitment to any aspect of the program is entirely voluntary, with the exception of those participating through a criminal justice diversion system. 6. Short-term Psychotherapy - The shift in treatment emphasis, beginning with this modality, is away from the solution of immediate, manifest problems to more long-range, generalized goals. - This mode relies upon one-to-one interviews with a professionally trained individual, usually a psychiatrist, psychologist, counselor, or social worker. - Short-term psychotherapy can be used until the client's inner growth forces are able to function adequately; it does not encourage lingering dependency. The goal is to improve the client's self-image and ability to function--usually within a period of less than a year. - In most situations, the client is kept in this form of treatment only as long as he seems to be making satisfactory progress toward problem solutions. Clients are expected to observe regular appointment hours (typically one appointment per week), be "ready" for help by realizing personal problems and actively seeking guidance, and must be willing to work through these problems to solutions. - Many psychotherapeutic practitioners specialize in one or another particular "school" of counseling theory: Gestalt, psychodrama, transactional analysis, brief therapy, client centered therapy, primal therapy, etc. - Selection of the most appropriate approach should be based upon the client's

characteristics. Thus, a key question is whether the client is more comfortable in fairly passive, verbal interchanges (client-centered, transactional analysis, brief therapy), or in more active therapeutic relationships (psychodrama, Gestalt, primal therapy).

- The psychotherapeutic process typically follows a basic pattern:
  - Realizing that there is a problem and that there is a need for help.
  - Establishing the client-counselor relationship, characterized by warmth, understanding, and supportiveness.
  - Expressing feelings and clarifying the problem(s).
  - Exploring the basis of feelings and personal resources.
  - Reaching an awareness of desirable direction of change.
  - Inducing change through reinforcement.
  - Developing insightful awareness and externalizing this awareness to situations beyond the immediate problem(s).
  - Evaluating and terminating the relationship.

7. Family Counseling and Therapy

The one-to-one psychotherapeutic process is often expanded to include the family; the therapist seeks to improve the functioning of the family as a group. There is an emphasis upon appreciating the differences between family members, an effort to improve communication, and a reconstruction of the flow of family interaction.

- The rationale for this type of counseling is the acknowledgement that the client's behavior doesn't occur in a vacuum and may be a response to either subtle or overt manipulation by other family members.

- Methods of treatment differ among individual practitioners. The therapist may work with one family per session or with several family units at once. Family members may sometimes be seen for individual sessions. In working with adolescents, therapists sometimes separate groups of parents and groups of adolescents. Exchanges between such groups are often made, with the children of one family meeting in sessions with other parents.

- Another technique is to bring families together in a crisis situation for an extended period of continuous confrontation.

- Under intensive study and treatment by the therapist over this period, the family is taught how to work through stressful situations. Appointments are scheduled regularly, and commit the participant to work not only on himself, but also on interpersonal family dynamics. The energy expended by the client in family therapy is usually quite extensive.

8. Extended Psychotherapy (Individual)

- Individual psychotherapy is an intense, one-to-one relationship that usually extends for a year or more.

- Emphasis is on significant personality change, brought about through a re-education of the individual at both the conscious and the unconscious levels. The therapist attempts to help the client gain perceptual reorganization, and integrate the consequent insights into his personality structure. Therapy has a depth-emphasis and is analytic in nature, dealing with the client's past life, present behavior, and rigid neurotic patterns.

- This modality differs from shorter therapeutic strategies in both the duration and the intensity of therapy. Quite frequently, several interviews a week are scheduled.

The therapist plays an active role in interpreting the client's behavior and in structuring and directing growth and change. Clients must be capable of active one-to-one involvement in the therapeutic relationship.

9. Extended Psychotherapy (Group)

- This mode involves professional therapy in a group setting. Intense personal problems rather than personal growth or even interpersonal relationships form the substance of group psychotherapy. The material discussed during group sessions is offered voluntarily by the participants; the environment is generally supportive and non-confrontive. Group members are encouraged to express intense inner feelings.
- This form of group treatment lasts typically from several months up to two years. Group sessions are held at least once each week. The program may or may not require individual therapy as an adjunct to group work.
- Several types of clients are inappropriate candidates for this treatment modality:
    - clients who are extremely aggressive or hostile;
    - clients who are regularly in close contact with one another outside the group setting;
    - clients who are fairly sophisticated in group processes and who tend to use their knowledge cruelly on others;
    - clients having very little contact with reality.

10. Group Encounters (Light)

- In this form of group treatment the client does not contribute voluntarily, but is drawn out by the group. The atmosphere, however, still remains supportive, and the emphasis is largely upon the client's positive attributes. Group participation tends to focus on inter-personal behavior and upon current behavior patterns that are observed by group members. For the most part, such material is dealt with on a contemporary and situational level rather than in a probing and analytical style.

- Group sessions are usually held from one to three times per week, and generally last from one to two hours. The average length of time spent in this form of treatment is rather short--generally from three to six months. Light encounter sessions are often in conjunction with other treatment approaches (e.g., alternative programs, community activities, etc.). In many programs clients are expected to participate in such additional activities.

- Care should be taken not to refer clients to this modality if they can be expected to disrupt a supportive group process. Also, clients who have very rigid defenses seem not to benefit from this lighter form of encounter.

11 Group Encounters (Heavy)

- Heavy group encounters are geared toward direct and sometimes violent verbal confrontation. Group sessions are characterized by a great deal of emotionality and a "no-holds-barred" approach. Everything verbal is permitted, forcing the client to face his own shortcomings and those of other group members. Participants generally learn to defend themselves well and are not permitted to show support for other group members under attack. Sessions may last several hours, and both duration and frequency of sessions are often determined by the group itself.

- This form of treatment is particularly useful for clients with rigid defense patterns.

12. Day-Care Activity Programs

- These programs generally operate during regular business hours, five or six days a week, and offer a varied program of relatively informal services, including vocational and educational training, "alternatives" programs, and some form of light therapy--individual and/or group. Clients are usually free to come and go as they wish, and typically allowed to involve themselves in whatever activities they choose.

- These programs are most effective with clients who have demonstrated past abilities to involve themselves in one-to-one and group relationships, and who have generally high scores on the Achieved Stake Index.

13. Ideological Groups (Non-Residential)

- The primary emphasis of programs in this category is upon a religious or ideological conversion in which the participant gives himself to the cause. There is usually a great deal of strongly supportive group activity. The basic treatment goal is usually to bring the client to the realization that he is fundamentally good, that he can salvage his own life, and that he can help others do the same.

- Daily routine is normally highly structured. For example religious programs usually include individual and group prayer, study of scripture, hymn singing, "witnessing," and group discussion sessions. A great deal of emphasis is placed upon instilling internal and external discipline. Strict standards generally are set--e.g., smoking and alcohol are often barred, language is monitored, mode of dress may be dictated, and recreational activities such as card playing are usually frowned upon. Many ideological programs segregate participants by sex.

- Clients often are expected to do outreach or street work to proselytize and bring in new "recruits." Average length of client involvement typically is from several months to a year.

14. Structured, Therapeutic Day-Care

- This modality intervenes more drastically into the client's life than any of the previously discussed alternatives.

- Clients are expected to report to the facility on a daily basis and to participate in a highly structured schedule of regular activities. Such activities include individual and/or group psychotherapy, vocational and educational counseling and related services (sometimes including vocational training, G.E.D. courses, tutoring, etc.), regular maintenance of the facilities, recreational activities, arts and crafts projects, and field trips. Activities are supervised and regulated by staff members. Participation in most activities generally is considered mandatory--one of the objectives being to overcome the client's own lack of internal discipline and structure.

- Occasionally, this treatment alternative is offered on a day-night basis. In these programs a second group of clients spend their evenings and nights at the facility. Usually, the evenings include activities similar to those held during the day, but such activities are geared to a clientele who are either working or attending school during the daytime hours.

- Structured, therapeutic day-care is recommended for clients whose drug involvement has been relatively short (less than one year) and who have poorly developed social strengths. Clients involved in heavy opiate use or serious multi-drug use, or clients who are living in an environment that encourages drug use, generally are inappropriate for this treatment alternative.

15. Inpatient Detoxification/Counseling

- During detoxification, the client is withdrawn gradually from drugs in a medical setting, often a hospital. In some cases, the dosage of the client's own drug is lowered gradually; however, most detoxi-

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fication programs now use a cross-dependent drug--e.g., methadone--to withdraw the client. A variety of medications may be given for symptomatic relief during withdrawal. Programs vary in length from two or three days to several weeks.

- This treatment alternative is appropriate for several groups of clients: clients with very well developed social strengths, regular involvement in a job or school, and a drug-free home environment; clients being referred to some other, predetermined treatment alternative, but who require prior detoxification; clients for whom no treatment referral decision can be made until withdrawal is at least partially completed. Further evaluation of this third group of clients should take place in the detoxification program, thus providing additional opportunities for appropriate motivational counseling.

16. Ideological Groups (Residential)

- Most of the activity in residential ideological programs focuses around the furtherance of some specific religious or political doctrine, and around teaching the client to aid the program in that effort. From the outset, programs in this category attempt either to enlighten the client religiously or to raise his political consciousness.

- Clients in this modality are expected to participate in and contribute to the functioning of the program. Daily activities are usually semi-structured, with religious teachings, worship, and rituals as a regular part of the religious programs, and political studies and action as part of the politically oriented programs. The availability of ancillary services varies considerably among programs.

- In contrast with previously-discussed treatment alternatives, clients in this modality must be able to make changes in their lifestyles in order to adjust to the residential setting. At the same time the demand for self-exploration and personality change is typically less than in the non-ideological residential programs.

- Clients with the ability for strong group involvement, but who have otherwise poorly developed social strengths, may do well in this form of treatment provided that the program's ideology is acceptable to the client. Many programs in this category also provide in-house detoxification for high-dose opiate and sedative users.

17. Halfway or Re-entry Houses

- Halfway or re-entry houses have traditionally served as temporary live-in facilities for those who have been released from prison or jail or from in-patient psychiatric care. For clients who have had drug-related problems prior to their confinement, these re-entry programs may be particularly appropriate [illegible] providing a temporary, drug-free environment during the transition to a noninstitutional life.

- Although similar in some respects to the ideologically based residential program, the re-entry house has as its primary goal the introduction of the client back into society rather than his religious or political conversion. Although a staff member is always present in the facility, residents are generally allowed to live quite independently, and their time is not highly structured. Clients may be encouraged to participate in individual or group counseling sessions; however, this is generally not mandatory. Recreational activities are usually available, and in some instances the re-entry program may work in conjunction with a day care facility to provide a wider range of activities. Vocational and educational counseling are often provided, as well as drug treatment referral services when required.

- The halfway house is recommended particularly for clients with well-developed social

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	strengths, and for clients whose pre-institutional environment encouraged drug use. It is also quite appropriate for clients who are involved in some constructive daily routine--e.g., a job or school. 18. Residential Therapeutic Community (Light) The objective of this treatment modality is to remove the client from the social environment in which he has been using drugs and place him in a drug-free living situation with others who are also trying to give up drug use. Thus, a primary therapeutic tool is the supportive peer interaction of the residents themselves. - The client of this treatment alternative is, in effect, placed into a new family, relatively isolated from the rest of society. Supportive individual therapy and mild confrontation group sessions are an essential part of the program. Daily activities are largely structured, and the client is expected to commit himself to daily participation in the program and to obey its rules. - Educational and vocational counseling and training are usually available, and vocational placement assistance is often provided. - This is the most intensive and all-inclusive treatment modality discussed thus far. It is, however, much less rigid in structure and much gentler in its treatment of clients than the heavy therapeutic community (discussed next). - Similarly, the length of treatment in this modality is usually less than that in heavier residential programs, averaging between three and nine months. - The light therapeutic community is recommended for clients with severe drug abuse problems of comparatively long duration, for clients who would otherwise

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	live in an environment that encourages drug use, and for clients who have recently been released from a prison or hospital. - Within each of these groups, clients with well-developed social strengths are likely to respond more positively to this form of treatment. 19. Residential Therapeutic Community (Heavy) - The basic assumptions underlying this treatment alternative are quite different from those of the light therapeutic communities. - In this modality, the drug user is seen as a person whose emotions and behavior have not developed past his childhood; he is therefore treated as if he were a naughty child and dealt with in a punitive and authoritarian manner. - The services provided are basically the same as those offered by lighter therapeutic communities; however, the manner in which they are delivered and the type of psychotherapy utilized are so different that the overall treatment effect is also quite unlike that of the lighter residential programs. The initiation period is usually longer and more strenuous. - The rules of the community are often structured rigidly; punishment for infractions are common methods for teaching the new client that he must conform to the policies of the program. The roles of authority within the community are rigid and hierarchical, with the most recent residents at the lowest levels of the hierarchy. Through time and good behavior, the client begins to achieve status and authority in the program. - The kind of psychotherapy used in this modality is heavy confrontation and attack therapy. The aim is to break the client down, to destroy his "street image," so that he will be forced into personality

change. Treatment lasts somewhat longer than in lighter programs, averaging from one to two years.

- This modality is recommended for clients with a lengthy history of serious opiate, sedative, or multi-drug abuse. It is particularly indicated for clients with poorly developed social strengths who have been living in an environment that encourages drug use, or who are returning from a prison or hospital.

20. Methadone to Abstinence

- This type of treatment provides the client with daily controlled doses of methadone. The assumption is that the client is capable of eventually abstaining from both heroin and methadone; the goal of treatment is to help him do so.
- The actual length of time on methadone may vary from program to program and from client to client; but in each case the length of time is specified at the outset of treatment.
- Many of the services and activities available through day-care programs are usually available. Group and individual psychotherapy are encouraged. Also, educational and vocational services are of particular importance in this treatment alternative. These services are often provided on a follow-up basis to clients who have recently completed methadone tapering.
- In contrast to the residential programs, this treatment alternative is offered on an outpatient basis, but the client's commitment to the program must be quite strong, since he is physically dependent upon the distribution of methadone.
- This modality differs from the more traditional methadone programs in that the client is expected to detoxify from methadone within a pre-specified length of

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	time, while traditional methadone treatment programs generally leave the time of detoxification unspecified. - Methadone to abstinence differs from other detoxification approaches in that the client is maintained longer on methadone and is supported with a wider variety of services. - This modality is recommended for clients with a lengthy history of involvement with opiates, but with well-developed social strengths and regular involvement in a job, school or some other constructive activity. - Methadone to abstinence is not recommended for those with poorly-developed social strengths or for clients living in an environment that encourages drug use. 21. Methadone Treatment Programs - In this treatment modality the client is provided with daily controlled doses of methadone for an indefinite period of time. - The goal is to allow the client as much time as he needs and wants to establish a life-style independent from heroin and from the crime often associated with its heavy use, before facing the problem of withdrawal from methadone. - In addition to regularly dispensing methadone, treatment programs in this category are required to make some form of psychotherapy available to clients. Many methadone programs now consider group and individual psychotherapy to be an integral part of their treatment plan. The usual spectrum of educational and vocational services should be available readily to all clients, including those who are in the process of detoxifying or who have recently completed tapering. - Although methadone treatment rarely offers the support and structure supplied by residential programs, this form of treatment does demand a serious commitment on the

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	part of the client--he must report to the program at least several times a week to obtain his methadone doses--for an indefinite period of time. - This modality is recommended for clients with a long history of opiate use who are presently involved in a regular daily routine of school or work and are living in an environment that does not encourage drug use. 22. Methadone-Based Residential Therapeutic Community - A single program may incorporate the services of both a therapeutic community and a methadone treatment program. Alternatively, the client may live in a residential therapeutic community but go outside the facility to a methadone treatment program to receive his methadone dose. - Clients taking methadone may live separately within the community facility, or all members may associate freely, regardless of their involvement with methadone. - However the services are supplied, this modality offers the most comprehensive form of treatment for long-term opiate addiction. - This treatment alternative is most highly recommended for long-term, heavy users of heroin, and includes a drug-free environment and strong peer support, in addition to the physical support of methadone, as essential parts of the treatment plan. - Heavy opiate users with major multi-drug abuse problems are also appropriate for this modality. 23. Custodial Care or Hospitalization - This modality is recommended only when the client has serious medical or psychiatric complications that preclude less intensive treatment.

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- Clients needing this alternative fall into two basic groups: those whose acute medical or psychiatric disabilities suggest their temporary inability to participate in or to benefit from any of the treatment alternatives discussed already; those whose chronic disabilities preclude participation in treatment.

- The selection of these services for clients in the first group is generally made with the assumption that they will subsequently be placed in a treatment modality appropriate to their drug abuse problems.

24. Relaxation Methods

- Many chemically dependent persons have difficulty relaxing during the early phases of their return to abstinence.

- Various means have been attempted to aid them in relaxing. These include self-hypnosis, desensitization techniques, transcendental meditation, religious meditation, biofeedback mechanisms, and electrosleep. Despite the difference in nomenclature, theoretical orientation, and technical paraphernalia, the goal is the same: to rid the patient of muscle tension, a feeling of anxiety and dysphoria, and to alleviate insomnia and other psychophysiologic disorders.

25. Transcendental Meditation

- As taught, TM requires meditators to sit comfortably with their eyes closed for 20 minutes twice a day and repeat a Sanskrit sound or "mantra" silently to themselves. The physiclogical state which is induced has been likened to deep relaxation accompanied by mental alertness and is marked by a slowing of the heart beat, increase in skin resistance, reduction in oxygen consumption, and lowered rate and volume of respiration.

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26. Biofeedback

- Preliminary studies of biofeedback have focused almost entirely on its role in the treatment of psychosomatic disorders such as migraine and hypertension.

- In the addictions field, its clinical use as a relaxation technique is based on the principle that many chemically dependent people consume alcohol or other drugs to reduce tension or relieve depression.

- During biofeedback training, the subject is hooked up via electrodes to a polygraph equipment unit through which his unique physiological responses are transformed into electrical signals and amplified into an auditory or visual display. Experience with biofeedback in the treatment of alcohol abuse suggests that by learning to control such variables as blood pressure, pulse rate, skin temperature, muscle tension, and brain activity the alcoholic may be able to induce a relaxed state voluntarily, without resorting to chemicals.

- An extension of this theory provides that achieving mastery over his physiological responses acts as positive reinforcement of the alcoholic's ability to regain control over his drinking behavior.

27. Narcotic Antagonists

- There are two kinds of narcotic antagonists. They are "partial antagonists" and "pure antagonist."

- The partial antagonists are nalorphine (Nalline), pentazocine (Talwin), cyclasocine and levallorphan.

- The results of antagonizing the analgesic response to morphine with a narcotic antagonist such as nalorphine are complicated. Studies of nalorphine suggest that it is a "competitive antagonist" because the degree of antagonism increases as the dosage of the antagonist increases to a certain point and then declines with doses beyond that level.

- Cyclazocine antagonizes the analgesic effects of morphine but apparently is significantly less effective in antagonizing morphine-induced respiratory depression than either nalorphine or levallorphan. It is also known to antagonize the emetic and nausea-producing effects of morphine, which may be offset by the fact that it causes constipation in man.

- The antagonistic effects of levallorphan are numerous. It has been described as five to eight times more effective than nalorphine in antagonizing narcotics-induced respiratory depression. Levallorphan is also an effective antagonist for the analgesic effects of morphine, effects on circulation, and hyperglycemic effects, and is completely effective in antagonizing the antidiuretic effects of morphine.

- Pentazocine is considered a very weak antagonist and has been clinically useful as an analgesic, despite its shorter duration and one-half to one-sixth the potency of morphine.

- The pure antagonists are naloxone and naltrixone.

- Naloxone is a relatively short-acting compound, with a narcotic blockade of only four to six hours duration at normal dosages. It is also relatively ineffective in oral administration, and the high cost of a single 100 mg. oral dose required to block the effects of 40 mg. of intravenous heroin is prohibitive.

- Because of its potency and longer duration of action and oral effectiveness, naltrixone has definite advantages over naloxone in the treatment of heroin dependence.

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- The antagonists have four basic clinical uses:
  - they are useful in the treatment of narcotics addiction
  - they produce analgesia (a state of not feeling pain)
  - they can be used to diagnose narcotics and
  - they are effective antidotes for narcotic analgesic intoxication (blocking of narcotics).

28. Acupuncture

- The pioneer in the use of acupunture to treat drug addicts is Hong Kong's neurologist, Dr. H. L. Wen. The first reported research on this method was in 1973. Dr. Wen's original method was to relieve the withdrawal symptoms of heroin and opium addicts through controlled electrical stimulation applied to acupuncture needles inserted at specific points in the "concha" region of the addict's ears.

- "There is no doubt that one treatment with electro-acupuncture for 20-40 minutes, without the administration of any drugs at all, will dramatically alleviate the symptoms of acute withdrawal in any drug addiction," concluded British surgeon Margaret A. Patterson following a 1974 study using a slightly refined version of Dr. Wen's method.

- In a double-blind study of 25 alcoholics and drug addicts completed last year, Toronto General Hospital psychiatrist Albert Leung found auriculur acupuncture to be more useful in treating individuals with alcohol problems.

- A subsequent study by Dr. Wen indicates, however, that electro-acupuncture may have something over methadone as a withdrawal agent. Comparing two groups of 35 female heroin addicts, the Hong Kong acupuncturist found the average withdrawal time for those treated with electro-acupuncture was eight days versus 14 for those on methadone. After a one-year follow-up, the acupuncture group also had a higher abstinence rate.

- Experiences with this method have also focused on the need for follow-up rehabilitation programs. Says Dr. Patterson: "There is danger in the fact that the heavy drug user brought rapidly off drugs by electro-acupuncture stimulation must confront the reality that his life, being totally drug oriented, is now a blank."
- ARF researcher Dr. M. P. Lau poses the question of whether decreasing the suffering of the addict during withdrawal might act as a stimulus to further drug-taking and a higher incidence of addiction. "If it turns out to be true that acupuncture induces psychologically beneficial effects in man," he adds, "the human psyche would work in such a way that one would run the risk of becoming (psychologically) addicted to acupuncture. Tolerance may also develop."

29. Behavior Modification

- This approach has been employed on a limited basis over the last few decades.
- It consists of linking a punishment to undersirable behavior (such as drinking or not engaging in social interaction), or a reward to desirable behavior (such as sustained abstinence or social interaction).
- Among individuals who are employed, married, and belong to middle or upper classes, it has been fairly successful.
- The term "adversive" conditioning is often applied to the punishment approach. The techniques vary widely.

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	- In one of these the patient is induced to imagine uncomfortable or adversive experiences or perceptions (such as vomitus, nausea) in association with thoughts about drinking, or taverns, or the taste of alcohol; no physical means are used with this approach. - Sometimes somatic therapies are applied. For example, a patient may be primed with disulfiram and then given alcohol to drink, thus inducing a disulfiram reaction. - In a second method, a compound containing ipecac is given, followed immediately by a drink of alcohol; the ipecac induces severe vomiting within several minutes. - A third approach involves adversive electrical shocks (short of producing tissue damage) coupled with the drinking or drug-using behavior. Long-term studies have shown the efficacy of these methods, but they have not been compared to other treatment methods. - Reinforcement of abstinence and social interaction has also been employed. If the patient chooses not to use alcohol or barbiturates, or to attend group therapy sessions, "points" are accumulated. These can then be used to "purchase" group walks outside of the treatment setting, use of the telephone, or items at a canteen. - Elaborate "contracts" have been used on an outpatient basis with married couples or other family members, such as parents and a chemically dependent offspring. - In the case of a married couple, both partners experience rewards (in the event of abstinence) or punishment (in the event of chemical usage). The couples themselves determine the rewards before agreeing to the final contract form. An effective "punishment" might be the donation of a sum of money to an intensely disliked social or political organization. The

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	"rewards" ordinarily consist of behaviors or material objects which the partners give to one another in the event of abstinence, but are not exchanged in the event of usage. - This approach has been found useful following residential treatment during the early months of return-to-abstinence. The presence or absence of alcohol or drug usage must be ascertained by regular blood or urine tests. A few case reports indicate short-term benefit to this method, but again long-term controlled studies have not yet been done. 30. Education, Training - Virtually all treatment programs educate the patient and the family regarding the chemical dependency syndrome. They learn about early signs of chemical dependency, its effects on behavior and on the family, and the usual outcomes of the chemical dependency syndrome if interventions are not instituted. While the importance of this education has not been tested formally, most individuals active in this field believe that patients and their families gain considerably from learning about their disorder. - Some patients also benefit from special training involving their own behavior and interpersonal relationships. For those frustrated by or inadequate in their role as mother or father, parent effectiveness training can be beneficial. For excessively passive or superficially conforming individuals, assertiveness training can similarly help in dealing with their lives. - People who become incapacitated with chemical dependence during their adolescence or early adulthood may not have saleable skills or a stable employment history. Although chronologically and legally they may be adults, they are unable to achieve economic autonomy and support themselves in society--a major criterion

for social maturity. Until they can attain economic autonomy, abstinence per se will probably not improve their life style or increase their self-esteem.

- Such individuals need access to a variety of ensocialization programs including formal education, vocational training, on-the-job training, sheltered workshop, work-study programs, and industrial therapy.

31. Occupational and Industrial Programs

- Manifestations of chemical dependency usually appear fairly early at work. These include regular Monday morning absenteeism, repeated Monday morning "flu" symptoms (due to withdrawal), frequent unexplained absenteeism, appearance of accident proneness, problems with supervisors and fellow employees, and decreasing job efficiency. Thus, work is a logical place to institute early case finding.

- Over the last decade many large corporations, unions, professional groups, and government offices have instituted early case finding programs. The central figure in these programs is usually a chemical dependency counselor who works closely with union shop stewards, management, and the industrial health department (or private physician) in order to assess the patient, contact the family, and initiate treatment.

- Intervention by the counselor often occurs at a time of crisis, when the patient's continued poor job performance is about to result in imminent termination of employment. Offered the alternatives of treatment versus job termination, most individuals are willing to collaborate with a treatment program.

- In addition to motivating the patient for treatment, these programs also help keep the patients' jobs available until they are able to work. Once the employee has returned to work, the program personnel can assist in follow-up. Often AA meetings are held at the union, on the company's grounds,

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	or at the professional groups' association offices. - These programs have proven to be an advantage both to industry and to chemically dependent persons. They help retain valuable employees with good work records, so that the employer benefits from their experience and continued productivity. Industrial programs also play an invaluable role in maintaining access to employment for the chemically dependent person. 32. Self-Help Groups - In many instances these activities interdigitate with professional or institutional treatment activities, with referrals in both directions. Both professional treatment and self-help activities can occur simultaneously (although, of course, the clinician should be informed about the self-help activities). - In some instances that "belief system" of some self-help activities has been such that help-seeking from professionals or institutions is discouraged; however, this is now increasingly uncommon. • *Alcoholics Anonymous* - Alcoholics Anonymous was begun four decades ago by a few chemically dependent men, one of whom was a physician. Its membership now numbers in the hundreds of thousands, and it exists in every state in the nation and many countries of the world. It is a self-supporting organization, the goals of which are essentially a return to abstinence and control over one's own life. This is accomploshed by way of the "Twelve Steps," a guide for return to abstinence. Numerous training facilities and short-term courses are available, so that members can become alcoholism counselors. - AA meetings ordinarily take place weekly.

Regional or "open" meetings (i.e., for relatives of members and for nonmembers) may convene monthly. Members are urged to attend at least one weekly meeting. They may attend several meetings within a week, at groups located in different neighborhoods, or at meetings oriented for different professional or work groups. Those whose jobs require travel can attend meetings in other counties or states.

- In addition to the ritual aspects of the meetings, there is a fellowship recreational aspect that does not involve drug usage (if one excludes caffeine and tobacco--both of which are ordinarily consumed in great quantities at most meetings).

- *Alanon and Alateen*

- Alanon is an AA-sponsored group for the close relatives or friends of chemically dependent persons (most members are spouses). Alateen is for the adolescent children of chemically dependent parents.

- These groups provide invaluable support in helping the family through the crises associated with the chemical dependency syndrome and its treatment. Moreover, they educate the family to the chemical dependency syndrome and help them obtain a better perspective of their chemically dependent family member. They also inform members regarding how their own behavior might either exacerbate or relieve the chemical dependency syndrome.

33. Technical Aids: Telephone, Audiotape, Videotape

- The telephone has been used as a follow-up technique after residential therapy. Frequency of telephone contact varies from daily reports immediately following discharge, to weekly or monthly reports later on.

- Therapists have used this approach in rural settings where patients live a great distance from therapeutic resources, and with the elderly or physically incapacitated who have difficulty coming to a treatment facility. Relatives, friends, and fellow workers can also be contacted in this way to assess the patient's post-treatment course.

- Videotapes have been taken of patients in order to be viewed later by them. Events used for "videotape feedback" have included the patient's appearance and behavior while intoxicated at the time of admission, family conferences, psychotherapeutic sessions (either individual or group), and psychodrama.

- Most therapists concur that merely showing the patient a videotape of himself while intoxicated is a demeaning experience that does little to enhance the person's already deteriorated sense of self-esteem. If the patient's condition upon admission is shown, then subsequent improvements during the course of treatment in appearance and behavior should also be shown.

- The latter method demonstrates marked improvement to the patient and enhances self-esteem and self-confidence. Videotape feedback of psychotherapeutic sessions are also useful, especially when the patient has the opportunity to discuss the transactions viewed on tape.

- Audiotapes of psychotherapy sessions can also be reviewed by patients and later discussed with the therapist. They have also been used for learning relaxation or for desensitization. In the latter cases, the patient listens to a tape of the therapist's voice.

34. High Risk Group Activities

- In various treatment programs chemically dependent persons have engaged in a variety of risk-taking activities. These have included sky diving, "hard rock" mountain

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
15 minutes	climbing, and survival by oneself or in a small group for a number of days or weeks in the wilderness. - Such activities have been designed to bolster two deficits widely found among chemically dependent persons: (1) difficulty in trusting others; and (2) low self-confidence. In all of these activities one's very survival depends upon relying on others.... Once an individual has been through these experiences and survived, self-esteem and self-confidence seem to be enhanced. - None of these activities has been used in isolation. Rather they are adjunctive modalities usually employed along with residential treatment, such as the therapeutic community, halfway house, or long-term residential care. No formal evaluations have been reported. • Ask the group if they have questions about the material presented thus far. If so, respond accordingly.
5 minutes	• Summarize, stating the following: - Treatment is not the end of the road. It is the beginning of a process of turning an individual around from a self-destructive existence to a productive, self-sufficient life. - Treatment programs must help the ex-addict find and adopt alternatives to his old way of life. A range of rehabilitation options must be available to each client. Some individuals may need basic schooling, others vocational counseling or skills training. Some may need transitional supported work while others simply need a job. Goal oriented, realistic, positive counseling should reveal what a client needs. Ideally, we would like to see the

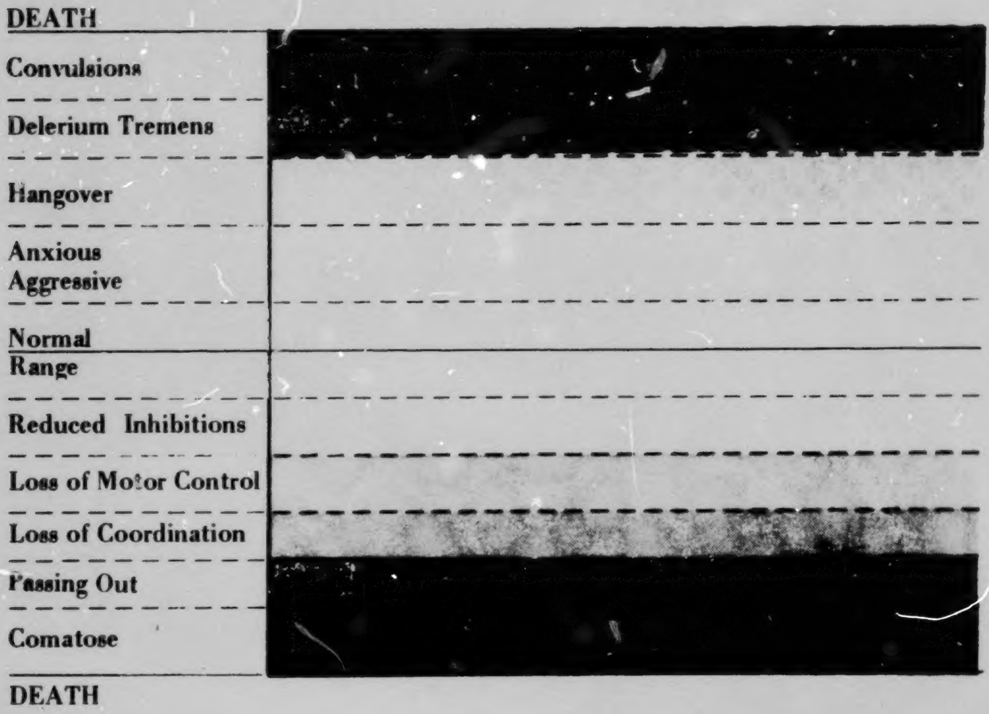
TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	range of options available to all individuals. - The wide diversity of treatment methods reflects the present lack of precise knowledge as to the nature of drug addiction and abuse. Uncertainty still exists regarding the causes, whether or not it is an "illness," and the degree to which the condition is physical or psychological. Policymakers continue to debate these issues while research is attempting to increase our knowledge of this complex social problem. - Meanwhile, even though treatment programs across the country are not "curing" some patients of the condition of drug dependence, nonetheless, for the majority, they are providing support and a marked degree of social rehabilitation for better functioning and a better life. END OF MODULE

ALCOHOL AND HEROIN

	Alcohol	Heroin
DEGENERATIVE EFFECTS	Serious short- and long-term degeneration	Pure narcotic — less short-and long-term degeneration of body organs and tissues than with alcohol.
CONTAMINATION	Controlled purity	Cut (mixed)
WITHDRAWAL	Frequently produces convulsions and death; -longer than 72 hours accompanied by severe symptoms; -DT's and convulsions; -can take up to two weeks.	Rarely produces convulsions or death. takes approximately 72 hours. (Methadone can be up to 6 months)
SOURCE	Formed naturally -product of fermentation	Formed naturally Opium – Poppy
COMMONALITIES	Potentiality of Addiction Severity of Withdrawal Process Can be used as a general anesthetic (depresses CNS) Can be used as a general anesthetic without developing addiction or compulsive use.	
LAW & SOCIETY	Legally and socially accepted (frequently socially expected by a majority of groups).	Illegal and socially unacceptable in the majority of groups.

CHART 1

REACTION TO SEDATIVE HYPNOTICS (PARTICULARLY ALCOHOL)*

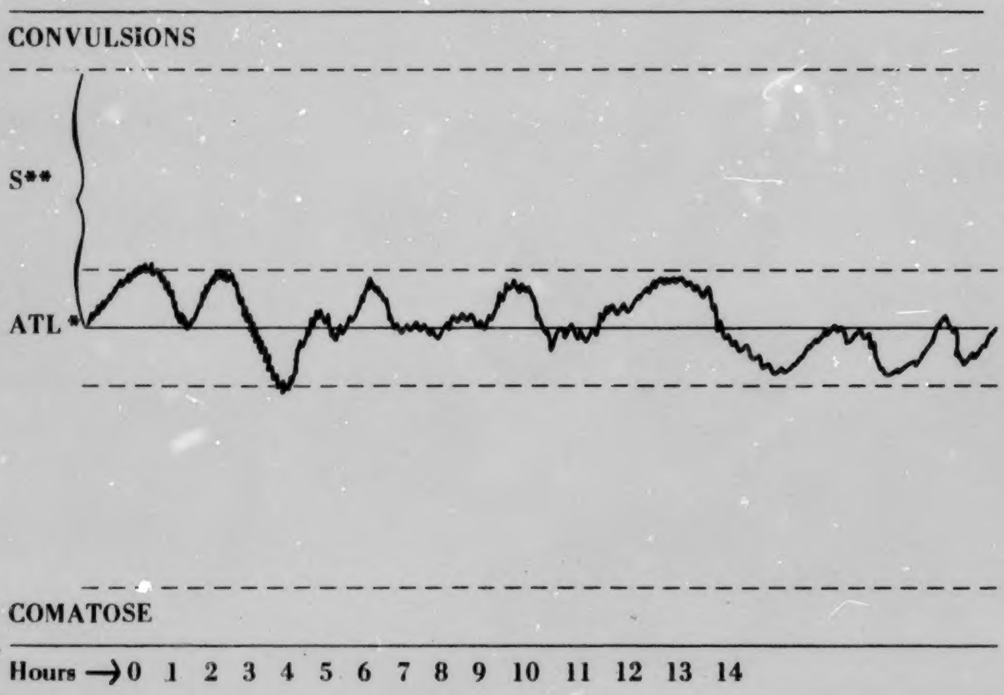

DEATH
Convulsions
Delerium Tremens
Hangover
Anxious Aggressive
Normal Range
Reduced Inhibitions
Loss of Motor Control
Loss of Coordination
Passing Out
Comatose
DEATH

---

*This illustration was developed by H. Stephen Glenn, and printed with the permission of Dr. Stanley Gitlow.

CHART 2

AVERAGE TENSION LEVEL

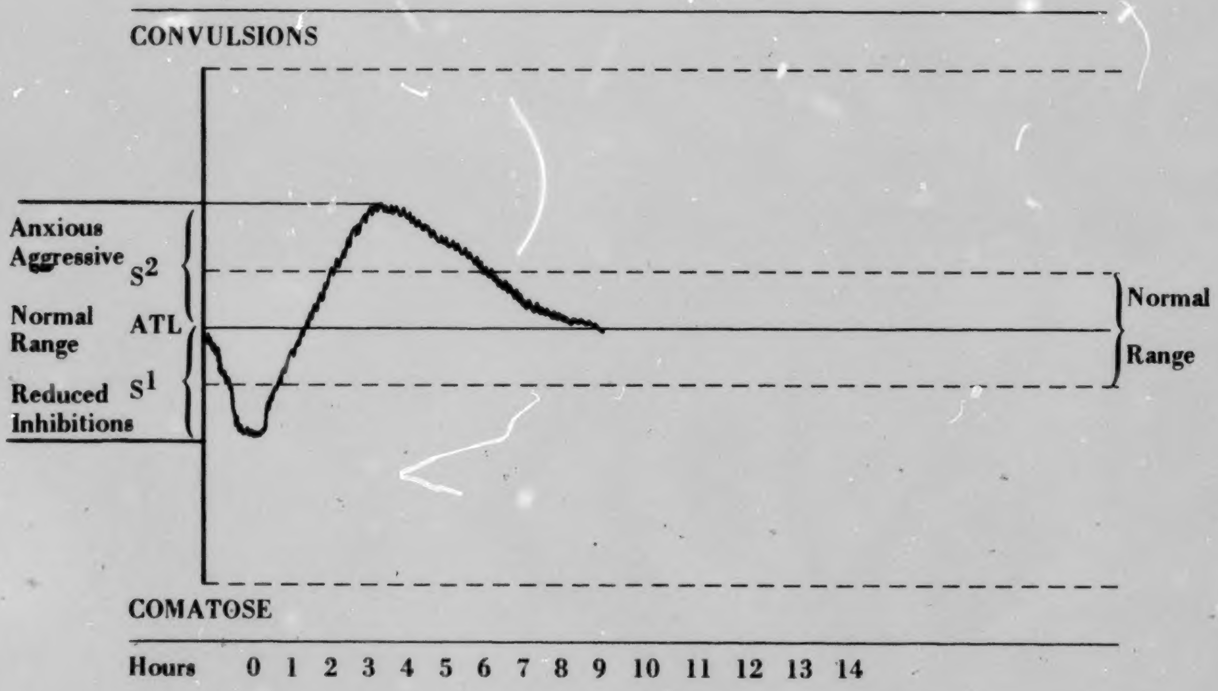


*ATL *Average Tension Level* varies with each individual.

**Average Amount of *Stimulation* Required to Produce Convulsion

CHART 3

TENSION CHANGES DUE TO ALCOHOL CONSUMPTION



(sedative effect)

S^1 Reduced tension level due to sedative/hypnotic consumption.

S^2 Increased tension due to psycho-motor stimulation.

CHART 4

THE BUILD-UP EFFECTS OF ADDITIONAL ALCOHOL CONSUMPTION

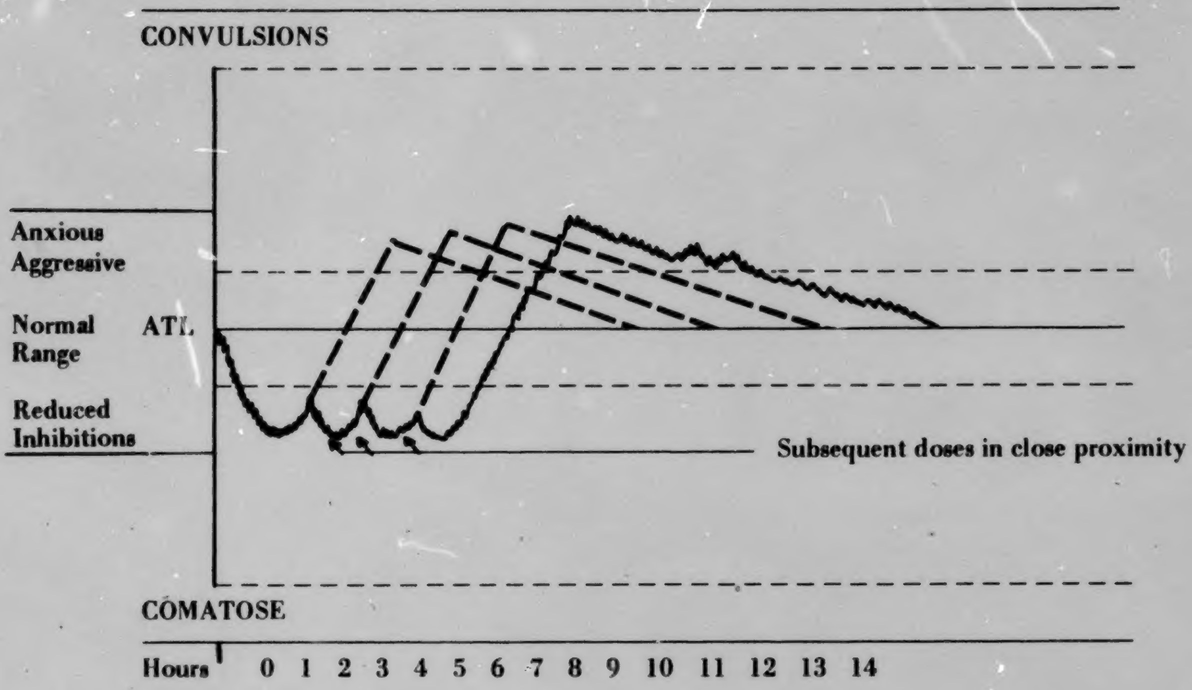
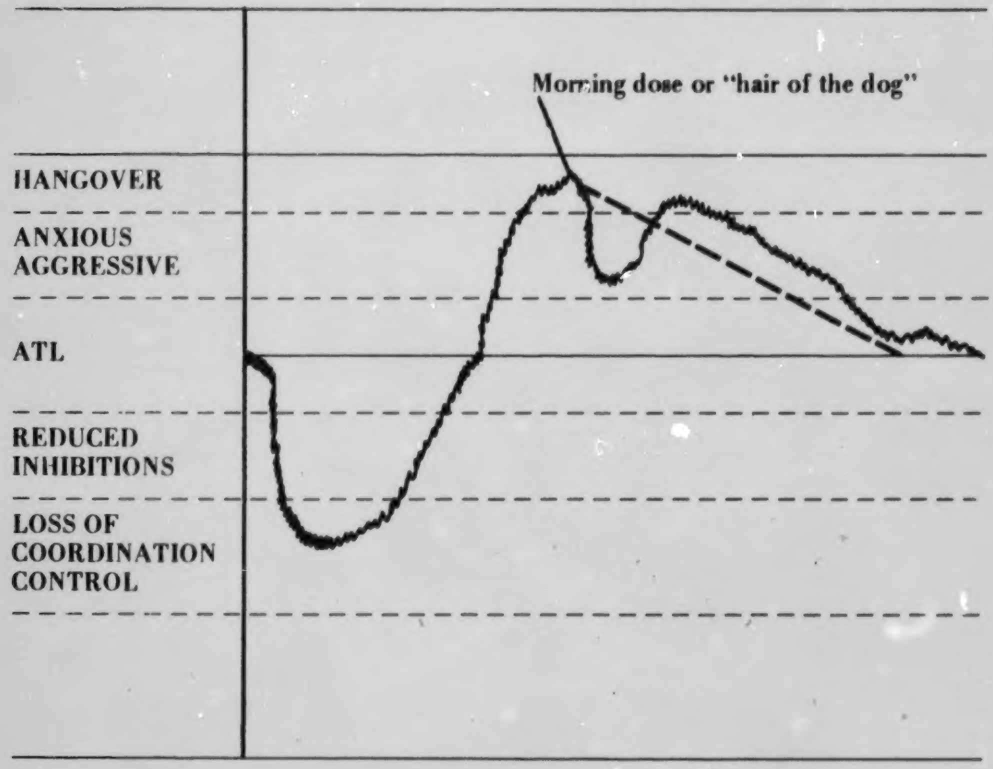


Figure 4

CHART 5

"HAIR-OF-THE-DOG" EFFECT *



*The term "hair of the dog" refers to the colloquial expression, "to recover, take a hair of the dog that bit you."

CHART 6

EFFECTS OF HIGHER ALCOHOL DOSAGES

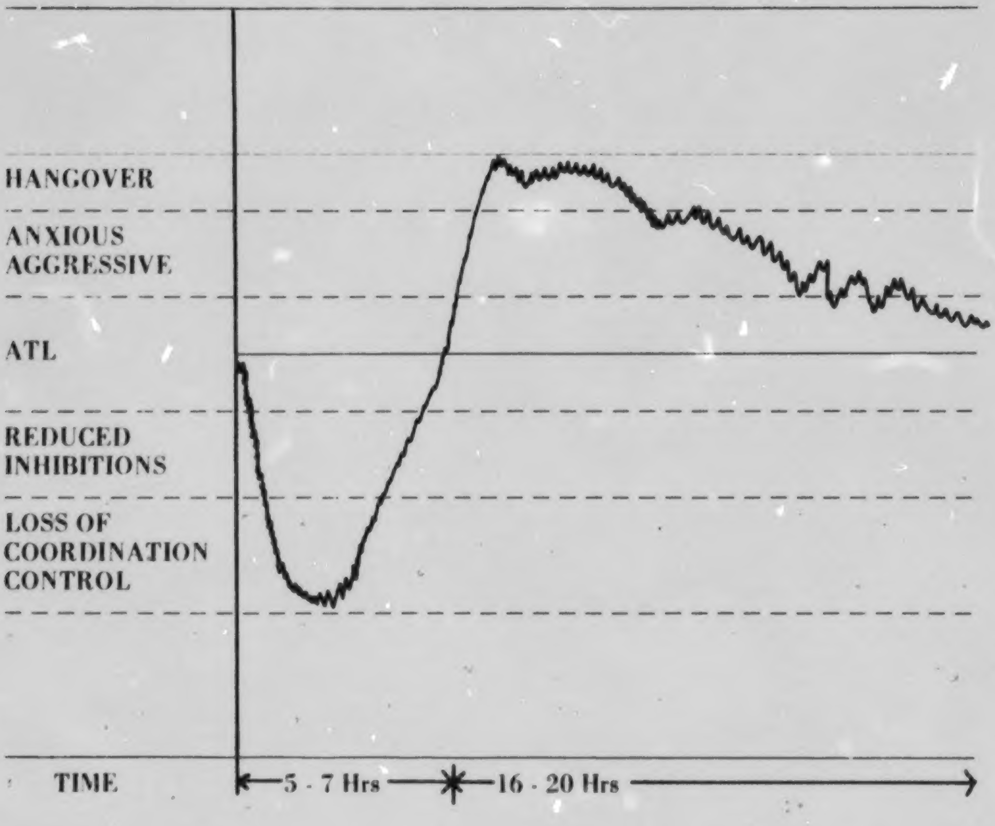
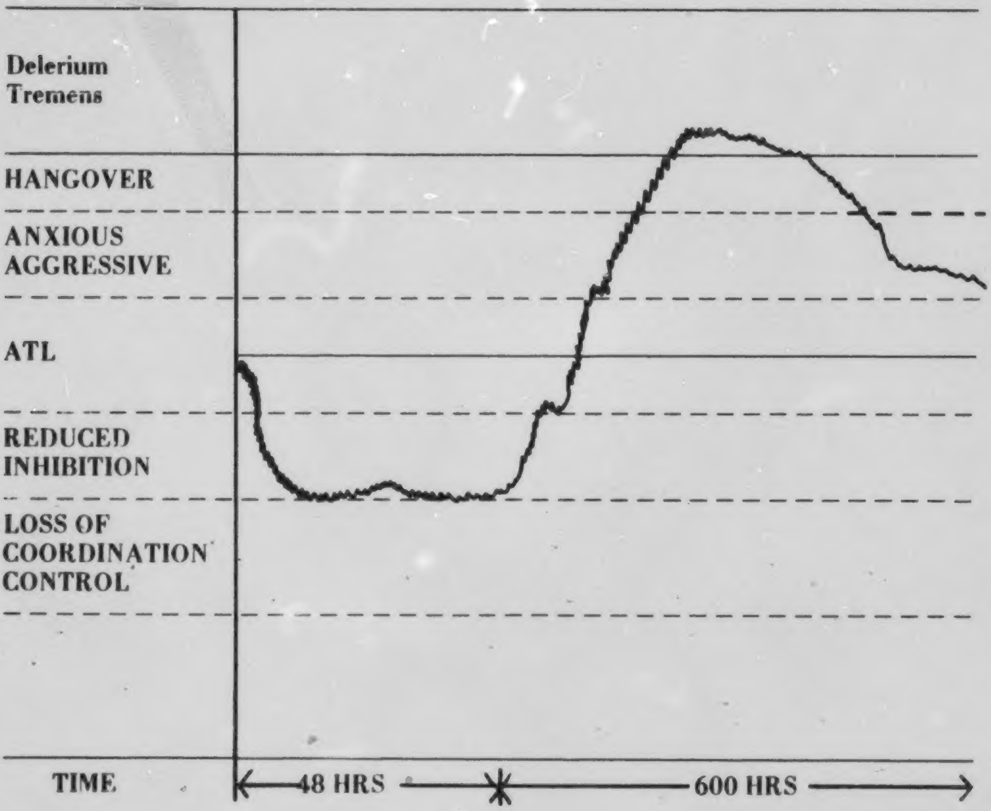


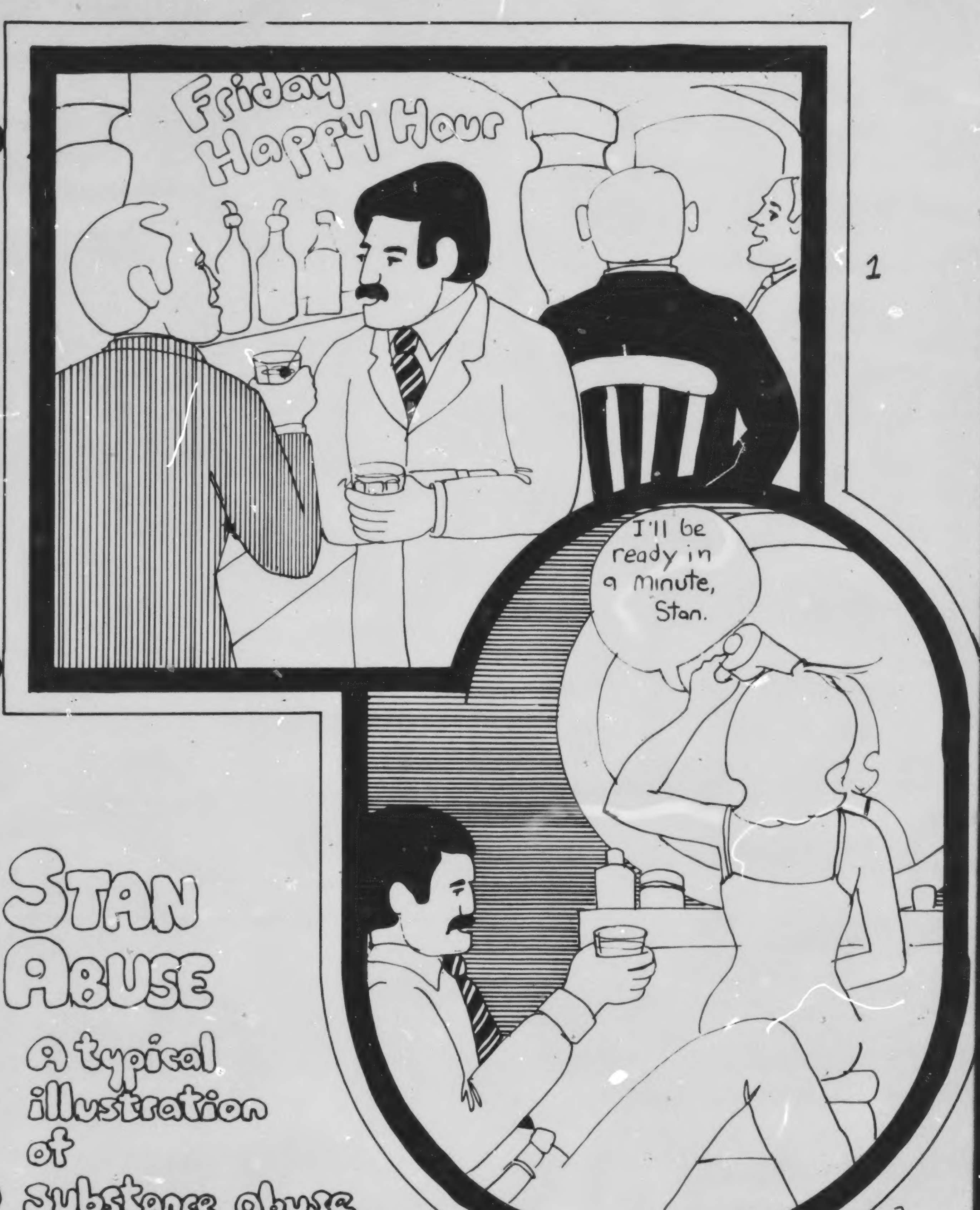
CHART 7

TENSION LEVELS PRODUCED BY FORTY-EIGHT HOURS OF HIGH LEVEL ALCOHOL CONSUMPTION



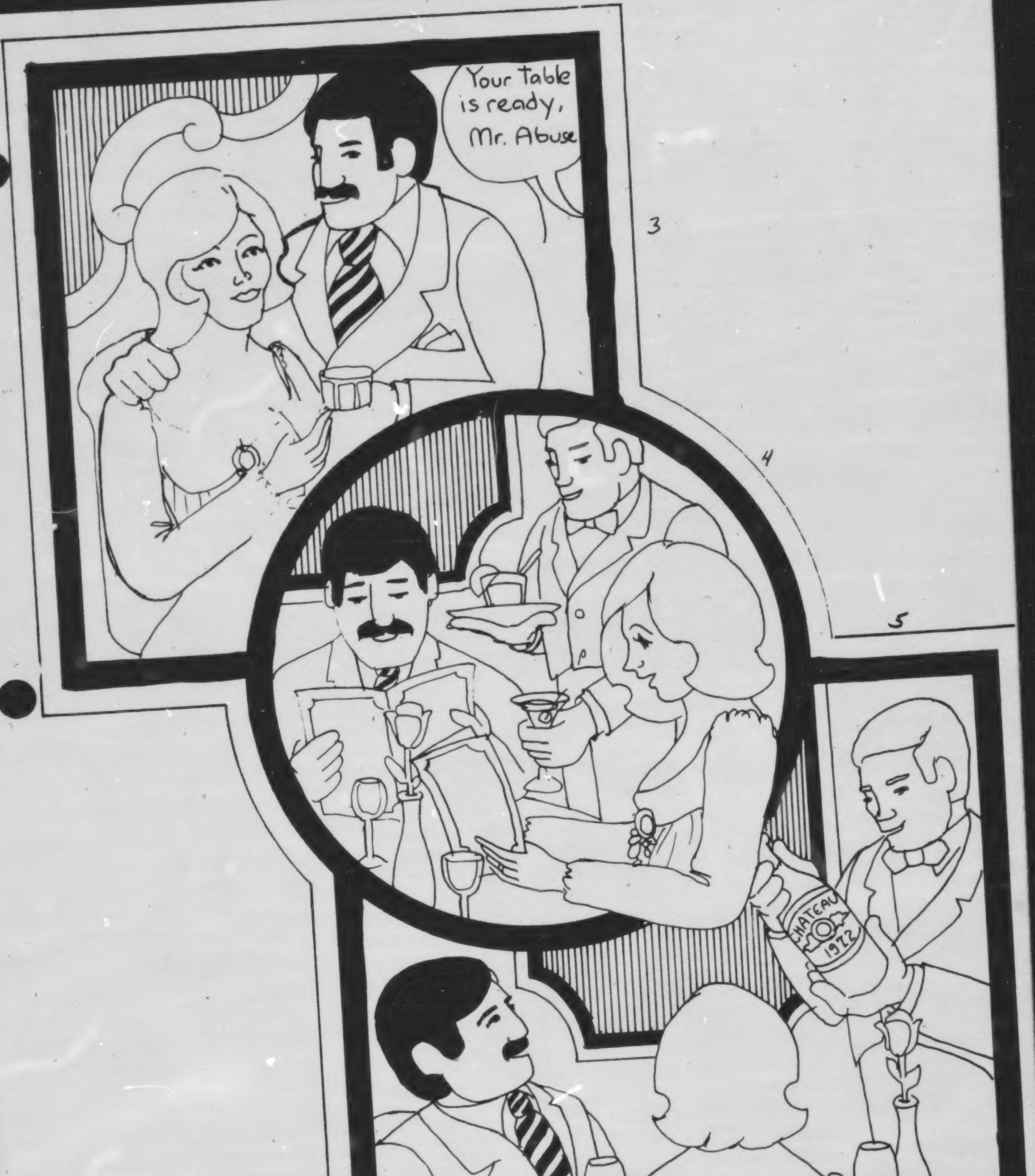
STAN
ABUSE

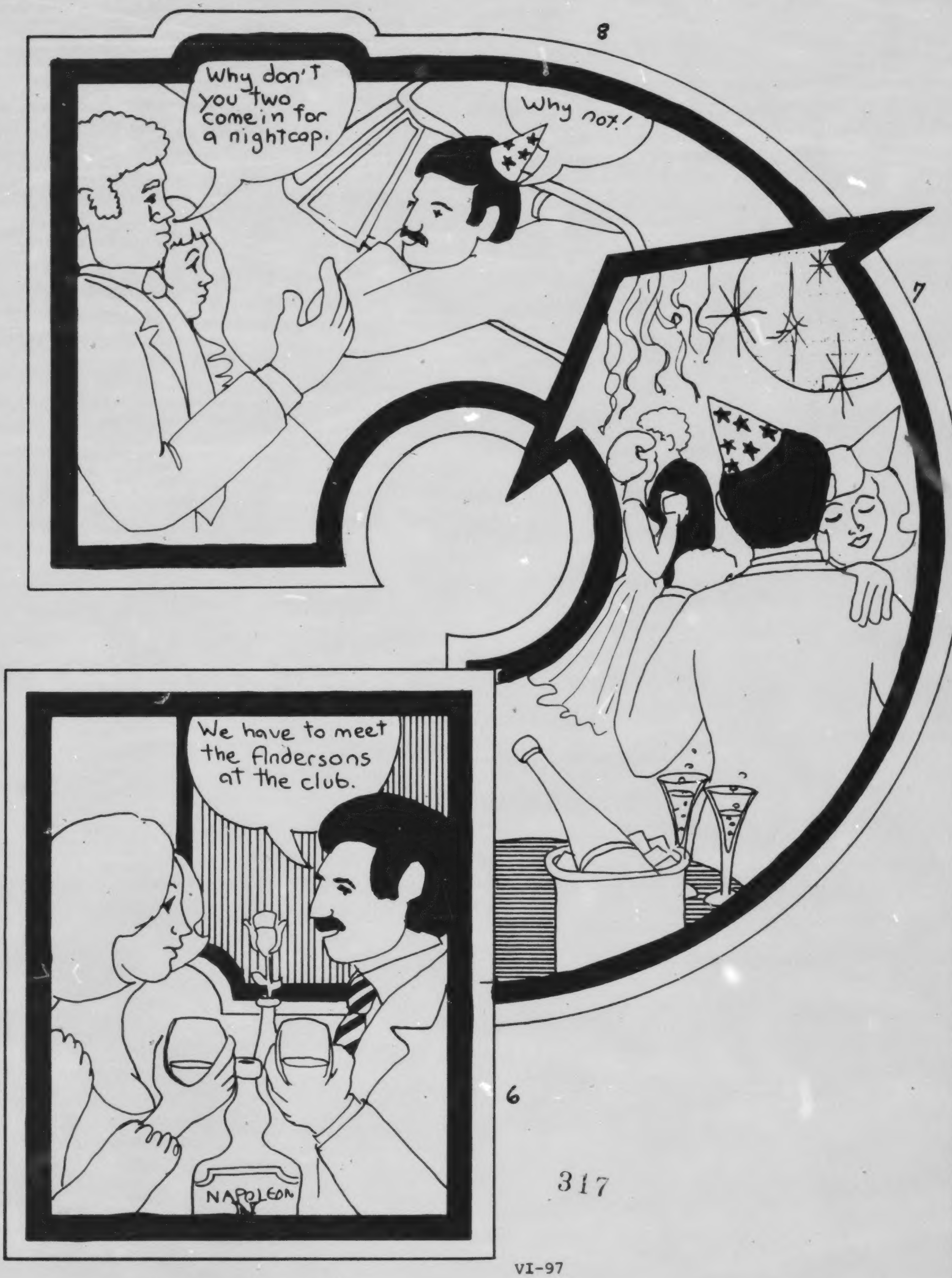
VI-91

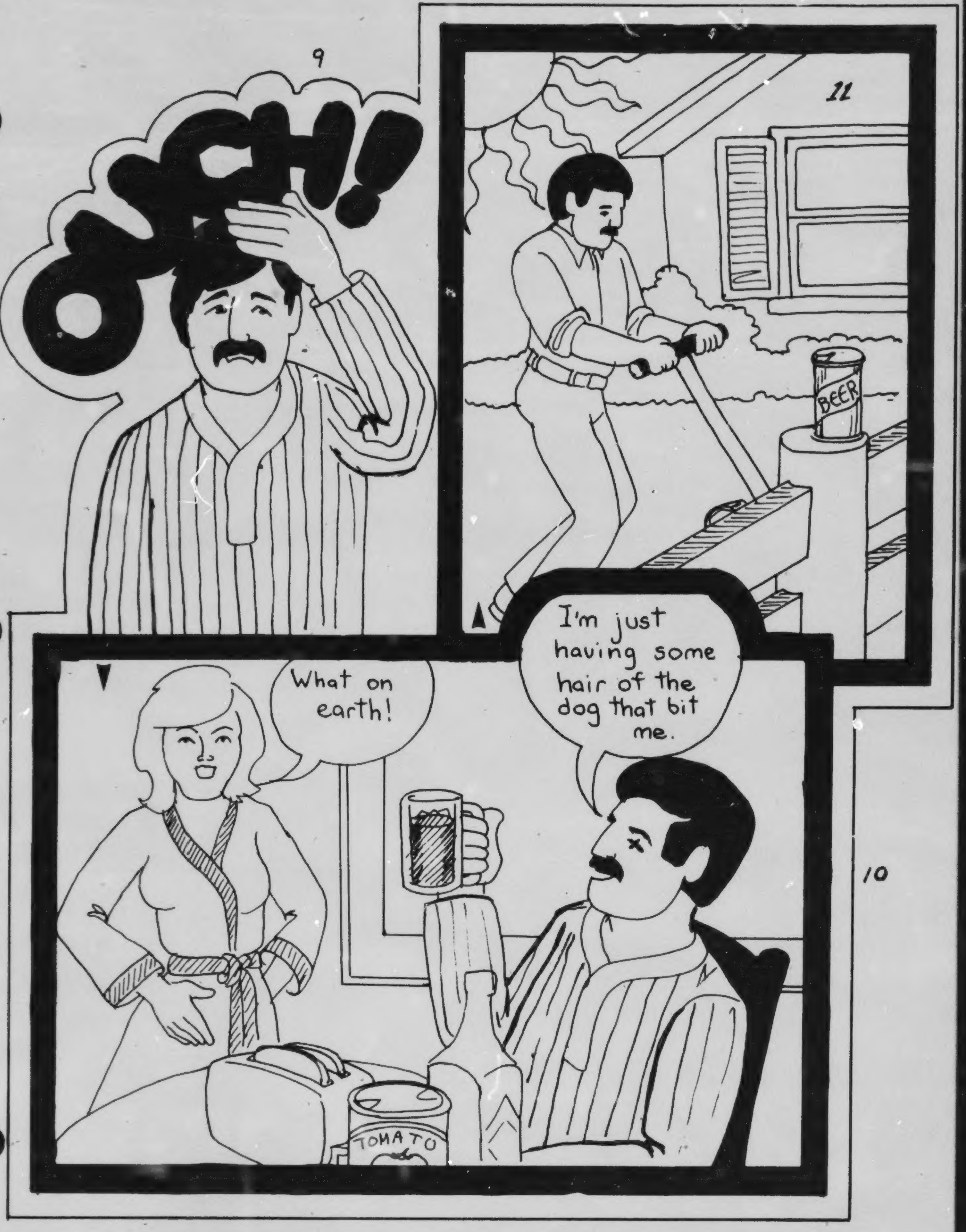

Friday Happy Hour
1
I'll be ready in a minute, Stan.
2

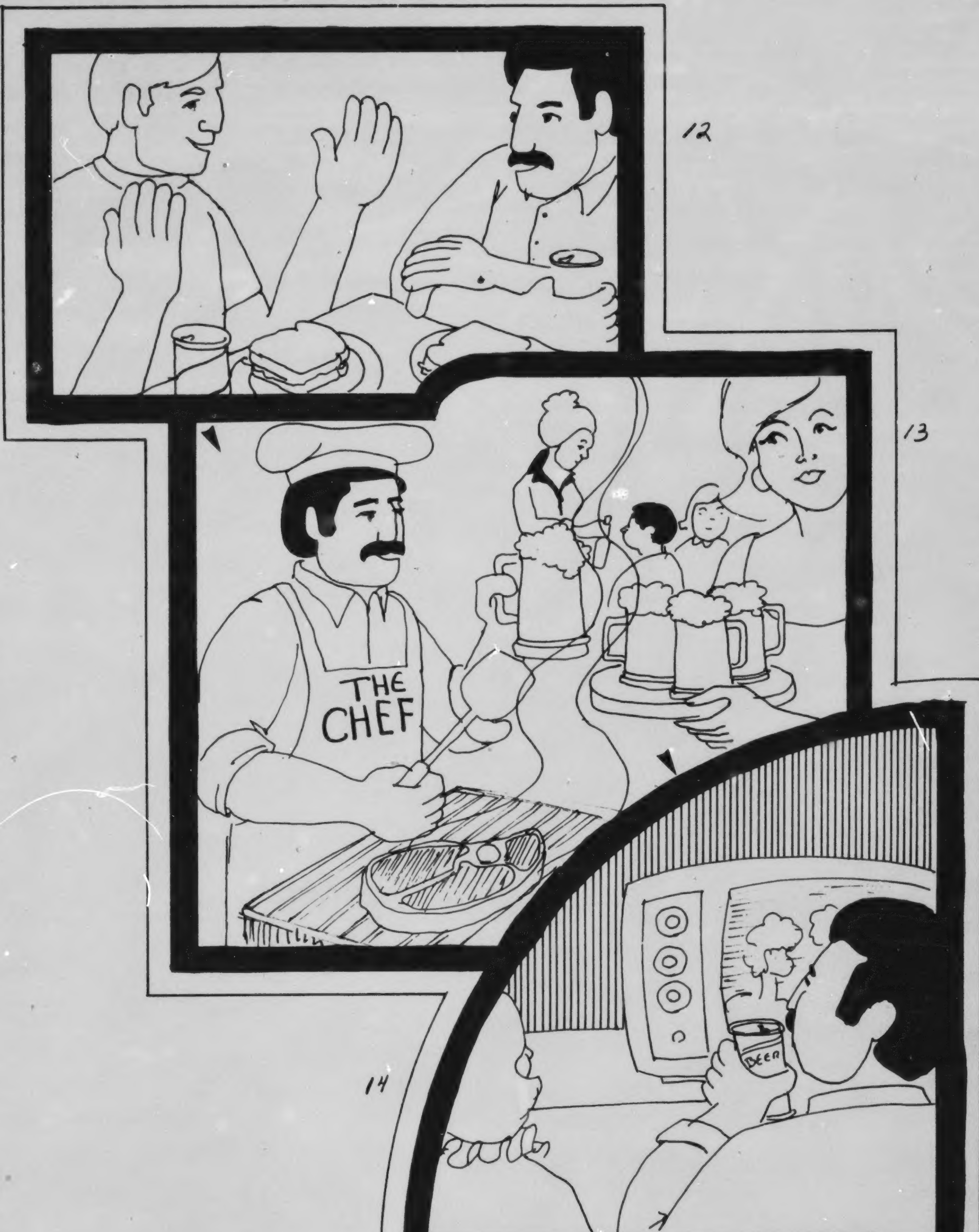
STAN ABUSE

A typical illustration of substance abuse

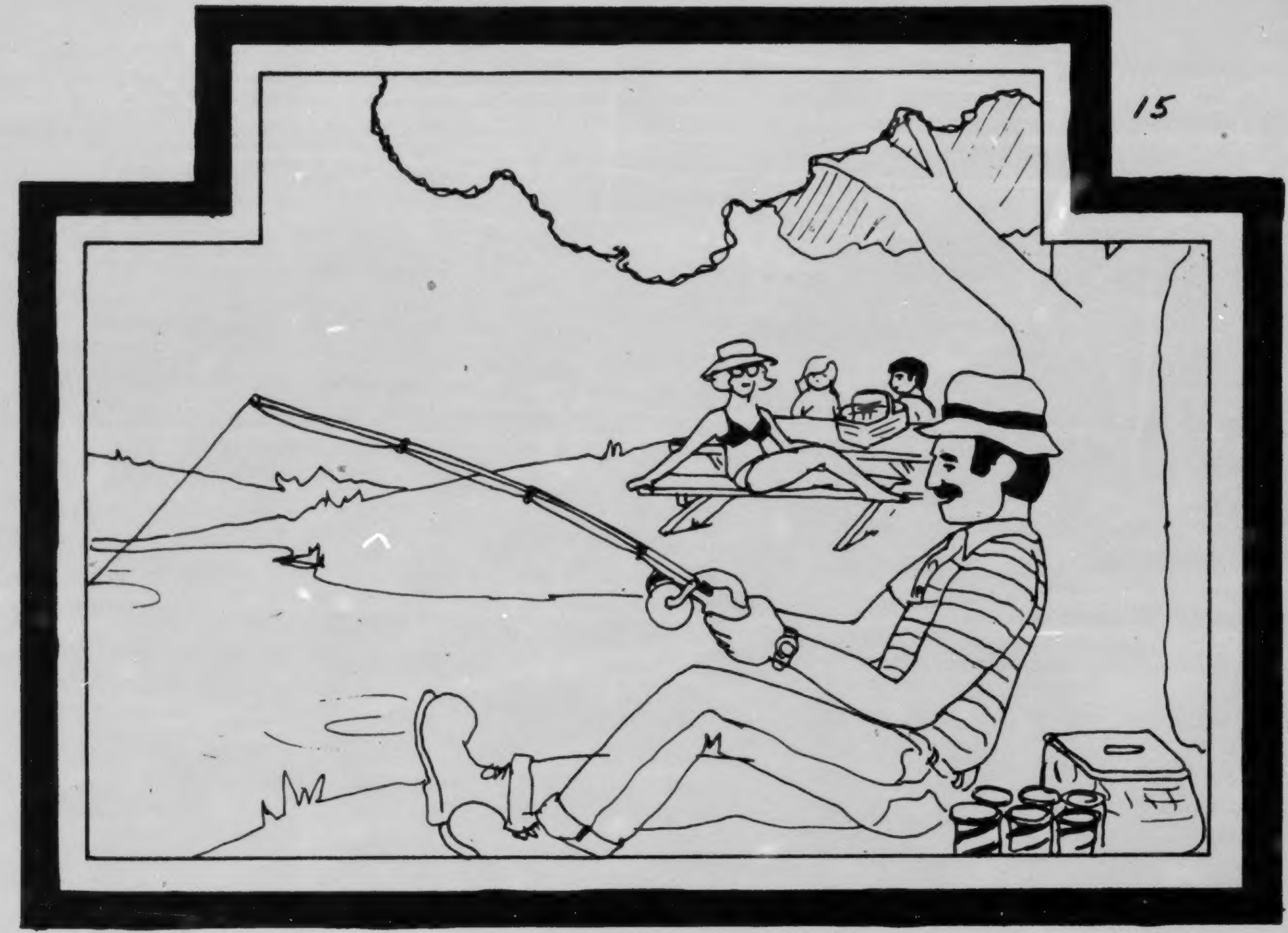

Your table is ready, Mr. Abuse
3
4
5
CHATEAU 1972


6
We have to meet the Andersons at the club.
NAPOLEON
7
8
Why don't you two come in for a nightcap.
Why not!

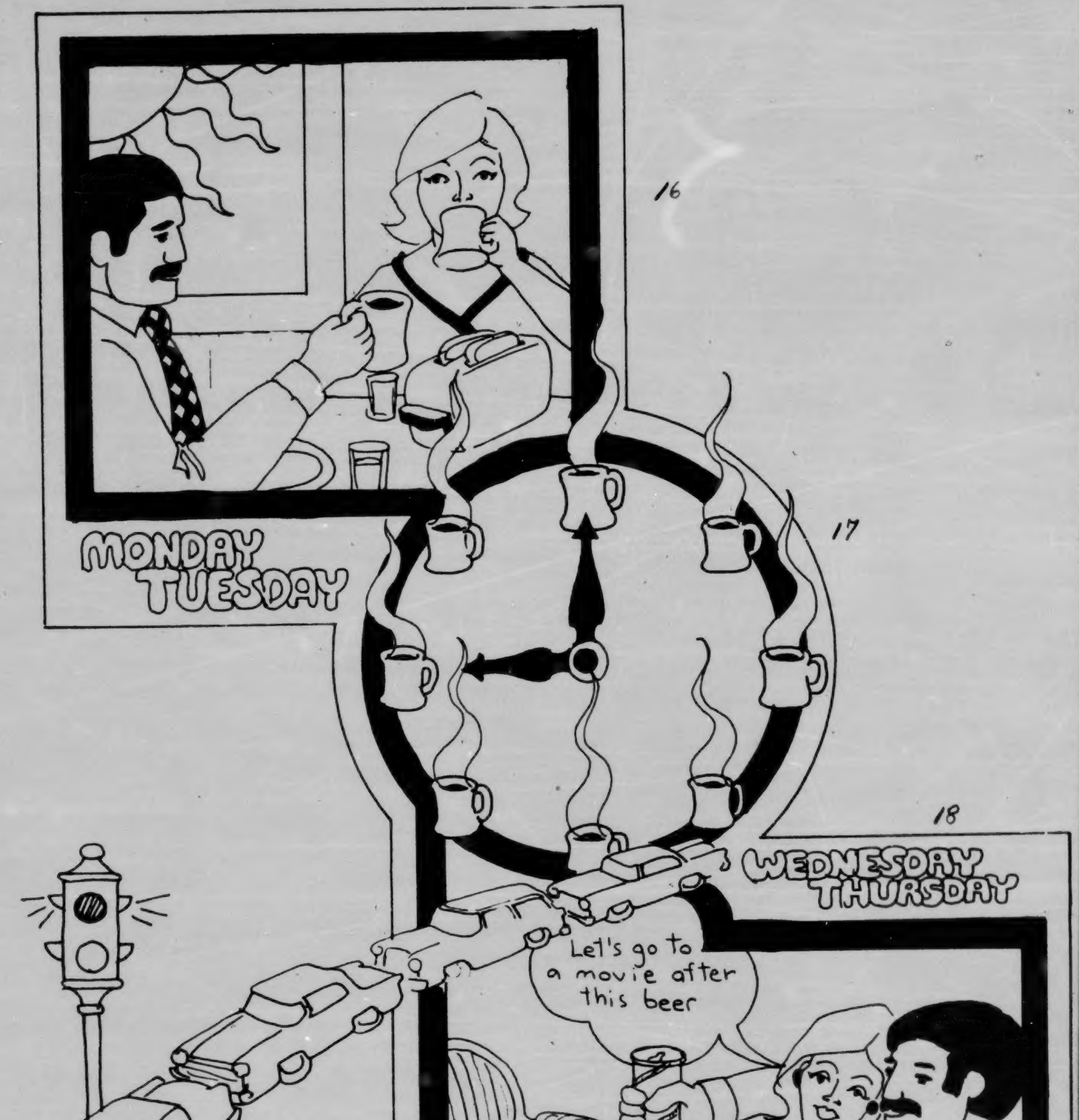

9
OUCH!
10
What on earth!
I'm just having some hair of the dog that bit me.
TOMATO
11
BEER

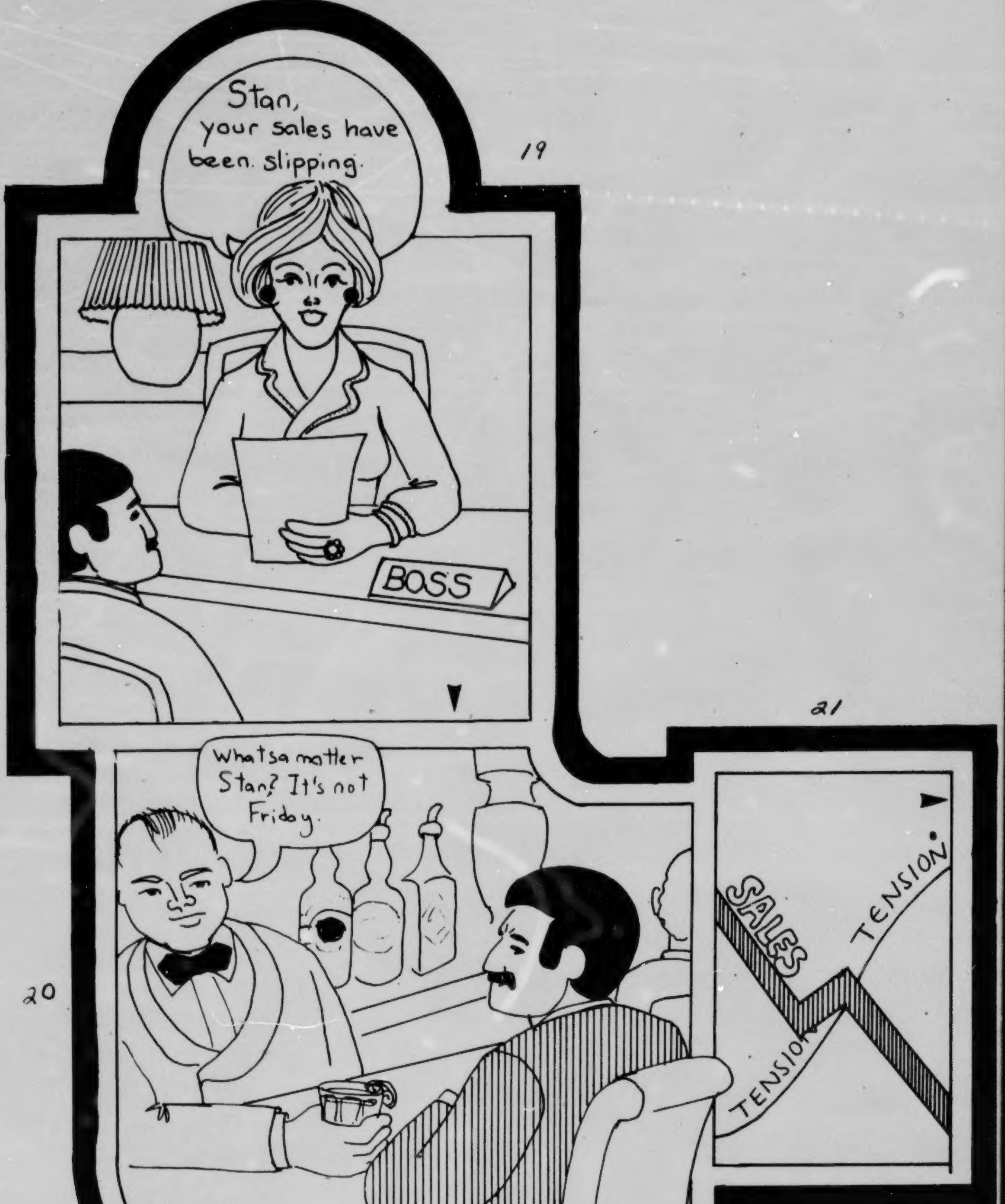

12
13
THE CHEF
BEER
14

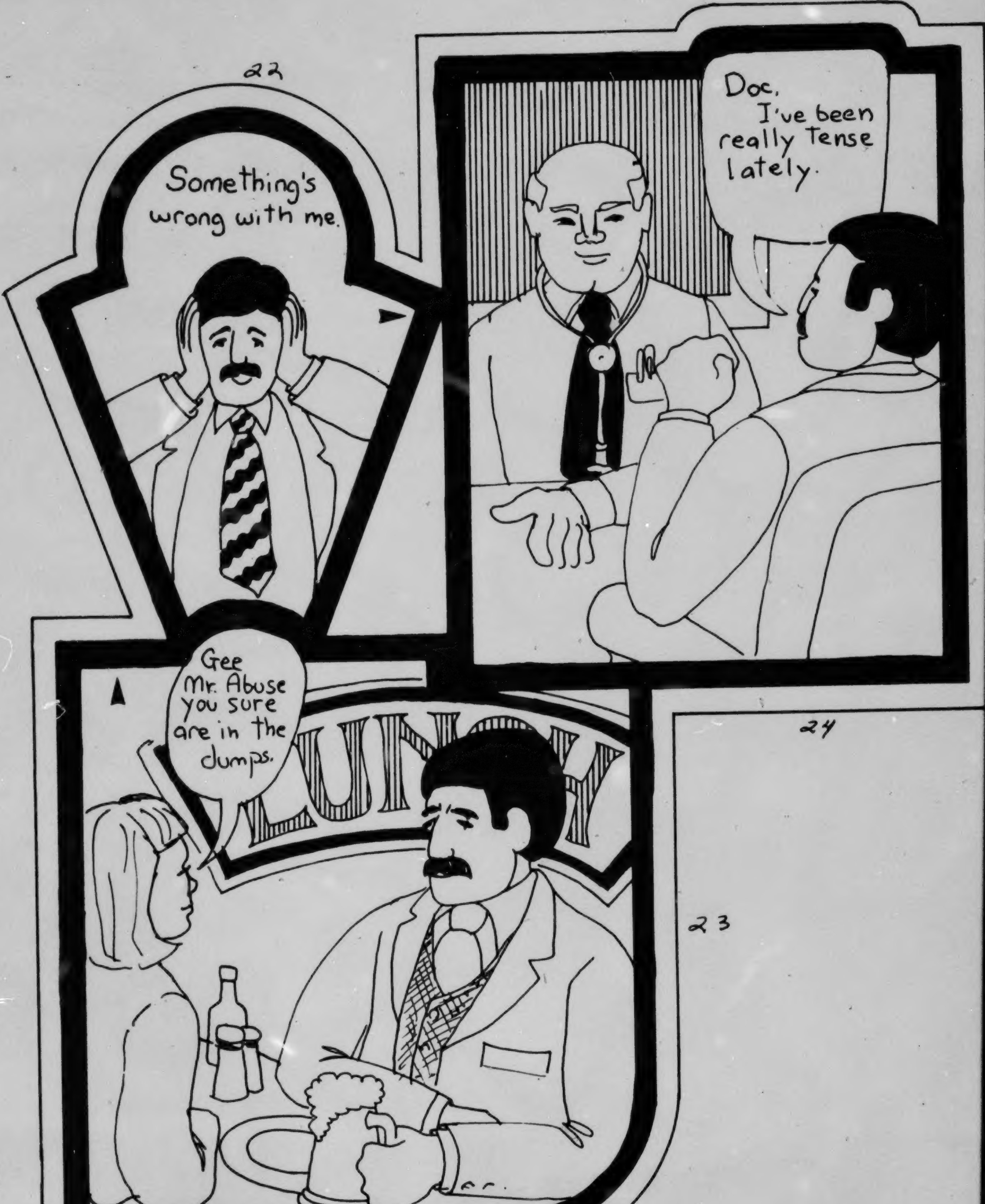
15

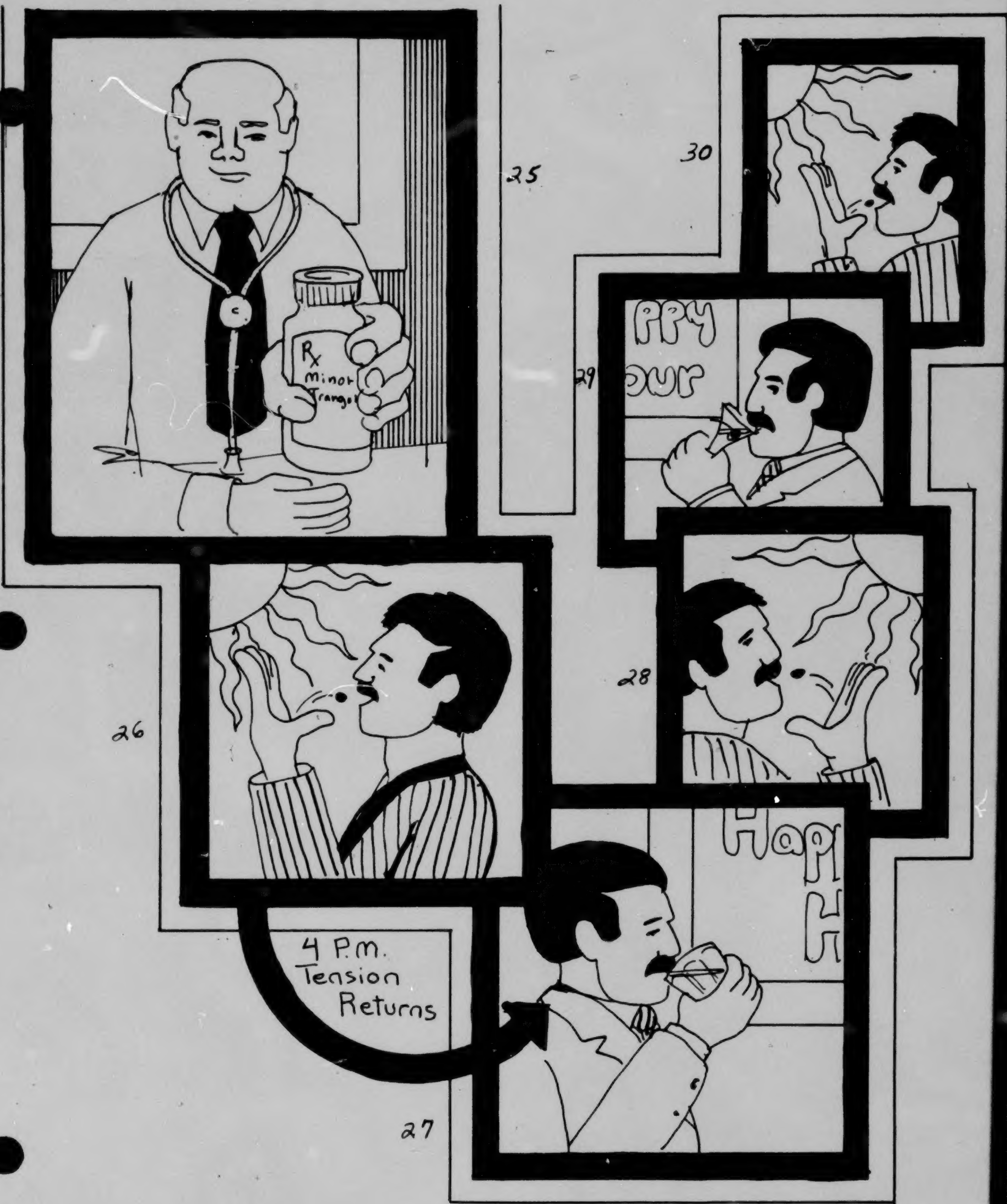


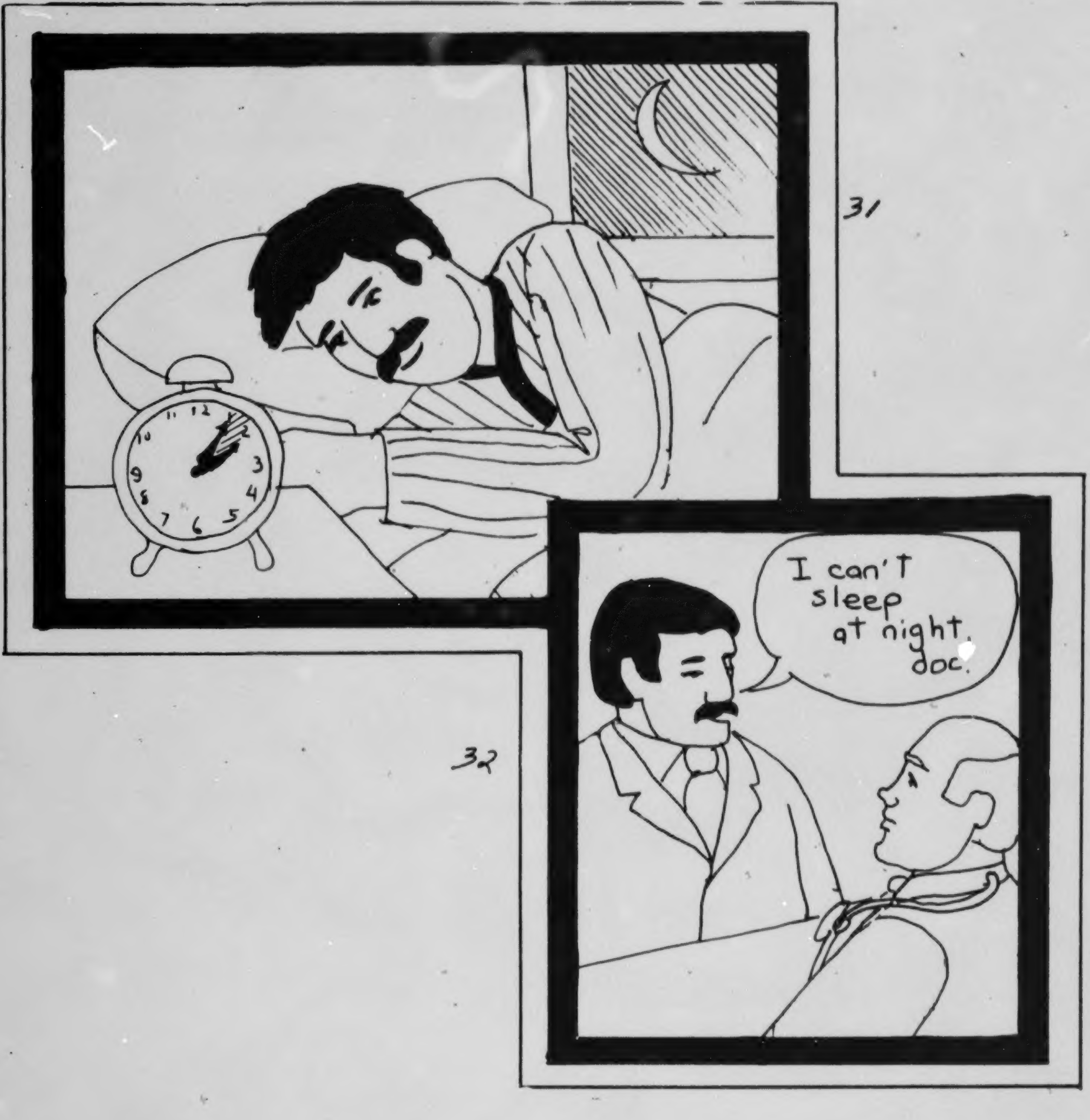
By Sunday night
he has a raised tension level
which will not return
to normal (ATL) until
Wednesday afternoon.


16
MONDAY
TUESDAY
17
18
WEDNESDAY
THURSDAY
Let's go to a movie after this beer


19
Stan, your sales have been slipping.
BOSS
20
Whatsa matter Stan? It's not Friday.
21
SALES
TENSION
TENSION
TENSION


22
Something's wrong with me.
Doc, I've been really Tense lately.
Gee Mr. Abuse you sure are in the dumps.
LUNCH
24
23


25
Rx
Minor
Tranq
26
4 P.M.
Tension
Returns
27
Hap
H
28
29
ppy
our
30


31
32
I can't sleep at night, doc.

This story illustrates
a tragic and unnecessary
pattern of life for millions of Americans.

REFERENCES

Glenn, H. Stephen; Warner, Joel; Hochman, Richard. "Substance Dependence." National Drug Abuse Center for Training and Resource Development, 1977. Unpublished.

Glenn, H. Stephen and Hochman, Richard. "Stan Abuse." National Drug Abuse Center for Training and Resource Development, 1977. Unpublished.

Pittel, Stephen et al. "Drug Abuse Treatment Modalities: An Overview." Unpublished.

National Institute on Drug Abuse. *Narcotic Antagonists.* National Clearinghouse for Drug Abuse Information. Report Series, series 26, number 1. October, 1973.

__________. *Treatment of Drug Abuse: An Overview.* National Clearinghouse for Drug Abuse Information. Report Series, series 34, number 1. April, 1975.

MODULE VII

PREVENTION AND THE COMMUNITY, SCHOOL, FAMILY, PEERS, AND YOUTH

MODULE VII: PREVENTION AND THE COMMUNITY, SCHOOL, FAMILY, PEERS, AND YOUTH

PERSPECTIVE

The purpose of this module is to provide information on, and give participants new ways to consider, drug abuse prevention efforts and the roles that schools, communities, families and peers, information, education, communication can play in dealing with drug problems.

This module includes:

- Overview of Module VII (5 minutes)
- Lecture/Discussion: Four Major Prevention Strategies (15 minutes)
- Lecture/Discussion: Prevention Based on Information (30 minutes)
- Lecture/Discussion: Effective and Constructive Use of Information About Drugs (30 minutes)
- Lecture/Discussion: Alternatives to Drug Use (15 minutes)
- Lecture/Discussion: Family, School, Peers, Community, and Youth (40 minutes)
- Individual Reading: Article by Dr. DuPont; report by the Cabinet Committee on Drug Abuse Prevention, Treatment and Rehabilitation (30 minutes)
- Summary of Module VII (15 minutes)

TOTAL TIME: 3 hours

OBJECTIVES

Using the information presented in Module VII as criteria, at the end of this module, and without the aid of notes, participants will be able to:

1. Identify at least four major strategies of prevention that correspond to drug-individual-context variables.

2. Identify at least three principles that can determine the effectiveness of information or communication related to drug abuse prevention.

3. Identify at least one key to the effectiveness of alternatives as a deterrent to drug use.

4. Identify at least four roles a family can play as a deterrent to drug use.

5. Identify at least one role a school can play as a deterrent to drug use.

6. Identify at least one role a peer group can play as a deterrent to drug use.

7. Identify at least two directions the Federal Government is taking to prevent the use of drugs.

MATERIALS REQUIRED

- Lecture Outline: "Four Major Prevention Strategies" on newsprint
- Lecture Outline: "Prevention Based on Information" on newsprint
- Lecture Outline: "Effective and Constructive Use of Information About Drugs" on newsprint
- Lecture Outline: "Alternatives to Drug Abuse"
- Lecture Outline: "Family, School, Peers, Community, and Youth"
- *"New Directions for the National Institute on Drug Abuse"* by Dr. Robert L. DuPont
- *Recommendations for Future Federal Activities in Drug Abuse Prevention, Treatment, and Rehabilitation*

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	OVERVIEW: MODULE VII ● Review the objectives of Module VII with the the total group. ● Explain the sequential flow of the module, highlighting: - Large group introduction to the content - Small group activities - Lecture presentation by the trainer - Large group discussion - Individual reading ● Introduce the module as follows: - When the drug user is recognized as a person, then as a person his integrity may be respected, his growth and development may be fostered and he can be helped in meeting his special problems and tasks. People in particular face problems and tasks stemming from the challenges of personal development. - The kinds of responses to drug use instigated are, as one would expect, directed more to the whole person than to his behavior with drugs. Some promising drug education programs may appear to have very little to do with drugs and drug use per se and, instead, present opportunities for the young, even those with problems, to move toward maturity in personality, character and soundness of judgement. - These so-called "non-drug-specific" responses are difficult to understand from the viewpoint of the legal model and even that of the medical or public-health model, in both of which the drug itself is a constant focus of primary concern. - By contrast, the responses and programs developed according to the psychosocial model contribute not only to the preven-

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	tion of, and care for, a youth's drug use problems but other personal and social problems as well. They are concerned with drug use or abuse in relation to the person as a whole and in the context of his or her needs, level of development and habitual ways of relating to all manner of problems. - Historically there have been four major strategies of prevention corresponding roughly to the four assumptions made about the drug-individual-context variables but also depending on further assumptions about behavior.
	NOTE: Be sure you have the following outlined on newsprint:
10 minutes	LECTURE: FOUR MAJOR PREVENTION STRATEGIES ● State the following: 1. First, prevention based on the moral-legal model rests heavily on punishment and threat of punishment for possession and use. - It assumes that punishment and threats of punishment will deter undesired behavior. - This leads to the passage of punitive laws and, at least theoretically, to the enforcement of those laws. - Behavioral research, as well as practical experience, suggests that punishment and threat of punishment deter only to the degree that, and as long as, punishment regularly and speedily follows a sufficiently high percentage of the occurrences of the behavior to be deterred. - The more prevalent the behavior be-

comes, the greater surveillance must be in order to keep the chance of punishment sufficiently high to serve as a deterrent.

- The kind and degree of surveillance required to make punishment serve as an effective deterrent when the proscribed behavior is private and frequent is often not acceptable to a given society because of other values it cherishes and other priorities it has.

- In some instances it will tolerate such surveillance for certain groups but reject it for others. It uses information about the dangers of proscribed drugs both to justify and to reinforce its legislative and enforcement efforts.

2. Prevention based on the medical or public health model relies heavily on the containment of known users to prevent them from "infecting" others, on the identification and treatment of individuals at risk and on drug abuse education as a sort of innoculation.

   - Drug abuse education based on this model assumes that all or most individuals value and seek good health and fear and wish to avoid disease.

   - Typical of this approach are the familiar campaigns against alcohol and cigarette use, which have been successful very rarely and only marginally.

   - All such programs which rely on information about the potential deleterious effects of individual drugs or classes of drugs depend on the assumption that information influences behavior, or that information influences attitudes which in turn influence behavior.

TIME/MATERIALS | TRAINER ACTIVITIES OUTLINE

3. Prevention efforts based on the psycho-social model of drug use and abuse to one degree or another place major emphasis on use or non-use as human behavior, as complex, as variable, as socially - and culturally - determined.

   - Information about drugs and how they interact with the human organism is not neglected, and there is often a degree of wishful thinking that colors the selection and presentation of the information.

   - Major differences between the use of information within this framework and within the other two are the assumptions that information indiscriminately given and passively received has little chance of changing behavior although it may reinforce existing behavior, that information, however carefully targeted, will not influence behavior unless it is actively processed and related to the attitudes, values and style of life of an individual or group, that decisions to use or not to use are often impulsive rather than rational and are influenced more by social factors than by information.

   - Information is thus one factor in discussions of values, of risk-taking behavior, of decision-making, or problem-solving.

   - But information as prevention is only incidental to attention to the personal and social needs that drug use may serve and the basic problems of which destructive drug use may be one manifestation.

4. Prevention strategies stemming from the socio-cultural model look to the social context of behavior for major change.

   - Rather than emphasize the adaptation

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	of the individual to the context or social environment, it suggests that factors in the context should be adapted to the individual and his needs. - Institutions, especially education, should be modified to be less impersonal, more humane; health and social services should be more client-centered and less professionally dominated; peer groups should be allowed to develop to meet the growth needs and styles of life of a variety of individuals; the social acceptability promotion of legal drugs should be diminished; the world of work should be more rewarding to the individual and less exclusively oriented toward profit-making; laws that do more harm than the behavior they are designed to control should be changed. - From a practical point of view, any strategy that does not take into account all four points of view will probably be ineffective. - Exclusive emphasis on drugs, on individuals or on social and cultural context will almost certainly be less than effective. - Deviant or destructive drug use cannot be dealt with out of the context of other deviant or destructive behavior; individuals behave as total entities, an individuals who think and believe and feel and act as an integrated whole; human beings are social beings and spend most of their lives in institutions that shape them and are shaped by them.
5 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
20 minutes	LECTURE: PREVENTION BASED ON INFORMATION ● State the following: - Education in the form of supplying information about socially disapproved drugs and drug users has long been used to generate support for social and legal action to control such drugs and their users, as well as to allay the anxieties and fears of those threatened by even the prospect of such use. - Such information has typically served these functions well if the number and nature of state, national and international laws and covenants designed to control such use and users are an indicator. - With the rapid rise in the use of illegal drugs in some countries and its spread to all segments of society, a first response on the part of some was a proliferation of the information that had been used in this support of social and legal action and was assumed to prevent "drug abuse." - Pamphlets proclaiming the disasters certain to follow use of an increasing list of "dangerous drugs" were distributed by the hundreds of thousands both by governments and private groups; television spots and documentaries filled the air waves, documentaries and dramatic films were produced and widely shown. Assorted individuals were assembled in groups of varying size from classroom or assembly to nation-wide television audiences and presented with films, cartoons, pamphlets, lectures by "authorities" varying from physicians to ex-addicts, without regard for the nature, pattern and extent of their drug use if any. For those who did not use illegal drugs and probably never would--because they perceived drug use as incongruent with their values, their goals and their styles of life, as a threat to

a stable perception of themselves and the physical and social environment which they value, as a decrease in their mastery of themselves and their environment which is important to their security and well-being and as representing social and legal risks which far outweighed any possible personal or social benefit--for these, such information reinforced their already strong resolve. But for others for whom adventure and daring were valued or sought as status symbols, whose goals and values were not traditional, who felt that they had little to lose and possibly much to gain, such information may have promoted at least experimentation.

- Within the past several years, education defined as selected information indiscriminately purveyed and accompanied by explicit or implicit exhortation has fallen into disrepute.
- It has been judged ineffective if not counter-productive in many instances.
- With its fall from favor, all information and all education have been questioned as effective strategies for prevention. Neither information nor education consistent in process or content with the best principles of behavioral science has been given a fair test. Moreover, education is not to be equated with information. Information, properly used, is a valuable tool of proper education.
- Information, with or without exhortation, has been and will probably continue to be a major prevention strategy for those who subscribe to the legal-moral or the medical-public-health points of view, not only for drug abuse but for all health-related problems.
- It is easier to implement and less disruptive to individuals, professions and institutions than the strategies growing out of either a psycho-social or a socio-

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	cultural model. - That it has been less than successful in most health-related problems will probably not diminish its use in drug use and abuse. Information, even with exhortation, as a strategy can function more effectively if it does so within the general framework of effective communication and persuasion. - If use of socially-disapproved drugs is the objective and information about drugs and drug use is the strategy, it is possible to make information much more effective than it has been to date, but only at a certain price. - Social science research has documented well the methods and techniques of effective communication and attitude change. Advertising and practical politics have long used them successfully. - They are based on very sophisticated analyses of the meaning and function of the attitudes or behavior to be modified or facilitated; they are carefully tailored to the value structure and style of life of well-defined and differentiated target groups; they make use of specified variations in the source of the information or communication, in the form and content of the message to be communicated and in the target of the communication, the individuals or groups to be persuaded. - The essence of any communication designed to influence knowledge, attitude, or behavior in a desired direction is who communicates what to whom. But basic to all three is a clear understanding of the goal or objective. - Communication in this sense is a tool to be skillfully used for a clearly defined objective.

- In the case of most communication designed to influence drug use, the objective traditionally has been to prevent or to stop illegal drug use.

- A professed objective is sometimes to provide information as the basis for informed decisions. For the first to masquerade as the second is often disastrous.

- A third objective may be to prevent the harm resulting from using drugs unwisely. Those pursuing this objective have usually come to the conclusion that in a given situation the first objective, abstinence, is hopeless even if desirable and that efforts to pursue it contribute to destructive use.

- Still a fourth objective may be to prevent escalation from any type of use to regular or to destructive use. In each case the objective dictates who says what to whom.

- Whatever the objective, there are basic principles which determine the effectiveness of the information or communications:

1. *PRINCIPLE #1: CREDIBILITY*

   - The perceived source of the information must be seen as both credible or expert and trustworthy by those to whom the information is given.

   - Who is expert will be viewed differently by different groups. Expertise may be judged in terms of professional qualifications.

   - If drugs as pharmacological agents are believed to be the key factor in drug use, pharmacologists and physicians are usually considered expert.

   - If drug use is perceived as behavior,

behavioral scientists or practitioners may be judged most knowledgeable.

- If, for reasons related or unrelated to drug use, all authority or establishment sources are suspect, users or ex-users may be considered the only experts.
- Expertise and credibility are judged by the recipient of the communication, not necessarily by any objective consensus. Such judgements vary from group to group, culture to culture.
- Information about the dangers of illegal drugs used primarily in support of, or in opposition to, certain legal, social and moral positions typically ignores at least three well-established facts about drugs.

- The first of these is the dose-response curve, the fact that the same substance produces different effects in different amounts. Effects attributed to socially disapproved drugs were primarily those of high-dose levels.
- The second basic fact is the overriding influence of non-drug factors such as the physiological and psychological characteristics of individuals, their expectations, and the circumstances under which the drug is used. Such influences are almost universally acknowledged for alcohol, primarily because it is so widely used. The more widely any drug is used, the more this fact is recognized.
- The third basic pharmacological fact, not unrelated to the second, is that any discussion of the effects of any drug, whether in relation to the effective dose, toxic dose, lethal dose, idiosyncratic reaction or side effects must be in terms of probabilities. The drug-individual interaction is so complex and so variable that no effect can be predicted with certainty. Credibility decreases in direct proportion to certainty and dogmatism.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- The primary effect of such information has been to decrease credibility and consequently to impugn the motives of those disseminating such information. Untruths, half-truths, exaggeration, overgeneralization and sensationalism kill credibility. What is said must bear some relationship to what is experienced by the great majority of users. Once credibility is breached it crumbles like a dam and generalized doubt and distrust remain. - For most drug users and for many other young people, failure to place alcohol use in the same context as other drug use, despite its legal status, and failure to place drug use by youth in the context of all drug use, are a certain formula for decreasing if not destroying credibility. 2. *PRINCIPLE #2: THE MESSAGE* - Characteristics of the message are equally important in determining the effectiveness of a communication. A major question is the degree to which contrary positions or counter-arguments to the desired effect should be included, excluded, presented first, presented last. - In general it is considered desirable to include all the arguments and to explicitly draw and justify the conclusion one wishes the target group to espouse. - If the target group is initially in support of the conclusion and is not likely to be exposed to the opposite position, opposition arguments may be ignored. - But, if the target group, although initially in agreement with the advocated position, is likely to be exposed to another point of view at a future time, mentioning and refuting this opposing policy will lead to greater resistance.

to future attacks on the position being supported.

- If the audience is supportive, opposing arguments should be mentioned and refuted before presenting the position to be supported; if the audience is naive the case should be made before mentioning and refuting the opposition case.
- If the group is a captive audience, extreme positions should be avoided since such positions will cause the neutral or hostile in the group to tune out.
- Positive appeals are more effective than negative ones.
- Subtle, qualified messages embedded in a broader context and related to or anchored in other values, goals, styles of life or related to the values and styles of other individuals important to the individual may not produce a strong and immediate impact but will increase the probability of a long-term, lasting effect.

3. *PRINCIPLE #3: THE TARGET GROUP*

- Characteristics of the target of the information or communication are equally important and equally complex.
- As seen above, they interact both with the source and the message.
- Users, non-users and fence-sitters react differently.
- Individuals with high and low self-esteem react differently.
- Individuals with different attitudes toward authority react differently.
- Individuals who are at risk need different

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	treatment from that appropriate for individuals who will in all probability never be exposed. - The results of the best-planned and executed informational or educational campaign are limited strictly by social and environmental realities.
10 minutes	● Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.
20 minutes	LECTURE: EFFECTIVE & CONSTRUCTIVE USE OF INFORMATION ABOUT DRUGS ● State the following: - There is a highly drug-specific informational or educational campaign that can be undertaken without concern for the knowledge, attitudes, values, styles of life, patterns of drug use, attitudes toward authority, level of anxiety or self-esteem of the target group. While highly drug-specific, it is not generally considered to be more than peripherally relevant to "the drug problem." By some it might be considered to contribute to socially unacceptable drug use. - A major problem facing all technological societies has been obscured by the great concern and preoccupation with socially disapproved drug use. It is the fact that everyone is living in an environment increasingly dominated by chemicals and is ill-equipped to live wisely in such an environment. - It is critically important that young and old alike understand how chemicals, whether they are called drugs or not,

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	interact with the living organism. Every individual should understand the fundamental principles of drug (chemical) action as the basis for wise personal, social and legislative action. The products of modern chemical technology are both a blessing and a curse. They can be used more safely and wisely to enhance well-being and relieve pain and distress; the harm associated with any uninformed use can be reduced; more intelligent planning and decisions regarding the chemical by-products of technology can be made. - In the opinion of some, such education may be the most constructive first step in reducing the myriad of problems associated with socially unacceptable drug use. - In an effort to take into account at least some of the problems discussed and, in addition, to avoid the danger of highlighting or glamorizing socially disapproved drugs and drug use, information about drugs and drug use is increasingly being incorporated into regular health curricula. In some instances it is incorporated as appropriate in such courses as chemistry, biology, history, literature or social studies. Such incorporation must be done with care and must be in the spirit of the whole course and not just as an excuse to add one more exhortation. - Inclusion in a broader curriculum has, at least theoretically, the advantage of adapting the material to the developmental level of the child. Concepts can be introduced and elaborated over a series of grades. - Teachers introducing drug-related information into any course should receive special training. Raising a topic concerning which there is so much discussion

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE

in the community and the media will raise questions and discussions which must be handled from a background of knowledge and understanding.

- It is also critical that the teacher be aware of the social, psychological, and developmental characteristics of a given class. By choice, a teacher should be equipped to introduce drug-related material as the need arises rather than to schedule it according to adult logic.

- One of the barriers to effective communication is the felt need on the part of some communities, schools and teachers to seize every opportunity to deliver one more dose of "vaccine." When communication is open and teachers are credible and trusted, young people are quick to indicate their need to know and the nature and level of that need.

- In responding to the need to relate information, attitudes and values regarding socially unacceptable drug use to the developmental needs of the individual, and to place them in the broader context of risk taking, of decision-making, of clarifying values, many groups such as families, schools, youth counseling centers have developed a variety of techniques designed to develop within a child skills that will enable him to make increasingly informed decisions consistent with his developing system of values.

- The continual interaction between decisions and values is an important learning process, one which never ends as long as the individual continues to grow. To encourage it is an act of faith in the child's basic need to grow.

- These strategies are firmly based in the psycho-social model. Information is not ignored for it is essential to any informed decision-making. It is assumed that for information to influence behavior

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	it must be incorporated into the active process of learning. - If the basic premises of the psychosocial model are accepted, the shape and form of programs and activities for families, schools, peer groups, and all the institutions in a given community are limited only by the imagination and commitment of the institutions in the community. In many instances they involve only doing differently what is already being done. In other instances, they provide an opportunity for mobilizing talents and human resources not being maximally utilized. In still others, they may involve major or minor changes in institutions. Change is always threatening in prospect; change that produces progress toward a valued goal is rewarding. - The various models described are not theoretical and it seems useful here to cite an example of their actual implementation. - The United States has probably put more faith in drug education and pursued it more vigorously than any other country. The people looked to the schools to accomplish what legislation, enforcement and treatment had not. - In addition, as drug use spread to middle and upper class people whose parents were uncomfortable in perceiving their offspring as engaged in behavior often attributed to the criminal or mentally ill, "education" seemed a more humane and socially acceptable way to proceed. - Across the nation, educators were persuaded that the drug problem was reaching crisis level and that they must respond at once. - Their first response was their natural

response, to provide students with information about drugs and the dangers of drug use. They rushed teachers to universities to learn about the chemistry of drugs or borrowed pharmacologists or pharmacists in order to administer large doses of information about drugs as either treatment of, or vaccination against, a "disease" they did not understand. At least they were doing something that came naturally, i.e., providing information on the assumption that it would influence behavior.

- It did not take very long for a school to become aware that many students were bored and unbelieving, insisting "that's not where it's at" and that drug use kept increasing either as a coincidence or possibly as a result. Gradually, in some instances in spite of themselves, school after school turned its attention to values, to decision-making skills, to problem-solving skills, to alternatives, even, in some cases, to examining what the school was doing or not doing to develop the kind of sound and mature person for whom drug use served no valued function. That is, they turned to non-drug-specific education. They put the psycho-social model to a test.

- And then their troubles began. A community still thinking in terms of the legal or medical models was not persuaded that they were doing anything to stop drug use. They were hard pressed to respond. Learning and growth take time. Everyone wanted instant measurable results. Instruments for validly and reliably measuring changes in behavior that is illegal are not readily available. Even if they were, many parents were reluctant to have too many questions asked lest they be faced with a problem they only suspected.

- One of the most dramatic testimonials for non-drug-specific intervention is that of a program in several public high schools located in high-risk areas. It is mentioned here only because it is one of the very few programs that has been at least minimally evaluated in terms of its actual impact on drug-related problems.

- The stated goals of the program are:
    - to establish a setting within each school where young people can go to learn to like themselves and to cope with one another;
    - to help students to make decisions, to solve problems, and in the process to grow;
    - to provide young people with intellectual, social, cultural, and recreational alternatives to drug abuse;
    - to improve communications with existing services within each school.
- The strategies for achieving these goals included group and individual counseling, training of a peer leadership group, tutoring, home visits, parent workshops, parent-child group sessions, community involvement, curriculum development, and in-service training of teachers.
- An evaluation study compared a random sample of 100 students from the program in each of two of the nine participating schools with a sample of 100 non-participating students from the same school, matched with the experimental group in respect to previous referrals for drug-related activities, instances of misbehavior, absences from school, grades in six courses, and sex. The number of referrals for drug-related activity and the number of drug related ambulance calls decreased significantly for the participating group after one year while increasing for the non-participating group druing the same period. The number

of absences decreased significantly for the participating group while the number of absences for the non-participating group increased. The number of instances of fighting with other students, fighting with faculty, abusive language, disrupting classrooms, damaging school property and stealing went down dramatically for the participating group while going up for the non-participating group. Average grades for the participating group were higher during the period they were in the program than before, while grades for the non-participating students dropped during the same period.

- The evaluators cautiously concluded that, on the basis of evidence from two schools, there was an association between participants in the program and improvement in socially desirable behaviors, and that there was some influence to which non-participant students are exposed that had the opposite effect. The other seven schools are now being studied.

- Most schools have a unique challenge and a special relationship to their diverse communities. Such a program within a school or a school system may be highly inappropriate in another school system in another culture or subculture. The particular program is described as an example of one based solidly on the psycho-social model and suggests that somewhere in every community there should be a place where young people can learn to like themselves and to relate constructively to one another; learn to make decisions, to solve problems and in the process to grow; to have an opportunity to develop their particular skills and talents through intellectual, social, cultural and recreational growth promoting activities--if the community cares.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
10 minutes	● As group members if they have any questions about the material presented thus far. If so, respond accordingly.
10 minutes	LECTURE: ALTERNATIVES TO DRUG USE ● State the following: - To recognize that the reasons for drug use are normal in no way commends drug use but it does provide a different perspective on drug use and a possible response, one that is gaining increased attention and popularity. This response is referred to as alternatives to drug use, and it is relevant to prevention, to early intervention, and to treatment and rehabilitation. - The assumption behind this approach is that people take drugs because they want to, that drug use serves some function, gives them some satisfaction in some area of their lives, and that they will stop using drugs or use less, if they find something better that will serve somewhat the same function, and that often does serve similar functions for non-drug users. The key to the effectiveness of alternatives as a deterrent to drug use is that they provide a more satisfying, or at least more acceptable, way of achieving and responding to the particular experiences sought with drugs. The experiences sought from drugs are myriad and often highly personal as well as social. By definition alternatives must be equally numerous and varied. They must span the physical, sensory, emotional, interpersonal, intellectual, developmental, creative, aesthetic, experiential, philosophical, socio-political. They may be exotic or extremely practical. Dramatic decreases in use of marijuana and hashish occurred spontaneously in a group of students studying meditation. Young men from socio-economically deprived backgrounds and situations in which drug use was high virtually stopped all drug use when enrolled in a job-training program that they

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	perceived as leading fairly directly to the realization of their personal and clearly defined aspirations. - As societies become larger and more diverse, institutions such as schools are being hard pressed to respond to the needs of all those encompassed in this diversity. Other institutions in the community, either existing or new, may have to take on some of the responsibility. In some countries, a wider variety of schools have been established, either within the regular school system, as an adjunct to the system or independently in the community. The wealthy and privileged in most societies have long demanded the privilege of creating schools that would respond to the particular needs of their children as they perceived them, as long as they were willing to pay the price. Alternate schools designed to meet the needs of youth not met by the regular schools are occurring with increasing frequency in some countries, at both the higher and lower socio-economic levels. The resourcefulness of communities or societies who value their children not as private property or merely as future economic producers and consumers but as those in whose hands the future of their society will rest, who are committed to fostering their optimal growth and development, in equipping them to solve problems as yet unidentified, may be worth watching. - Viable alternatives, in addition to being related to specific needs of functions, must contribute to individual identity and independence, provide for active participation, involvement and a chance for commitment, and provide relief from day to day routines.
5 minutes	● Ask group members if they have questions about the material presented thus far.

TIME/MATERIALS

30 minutes

TRAINER ACTIVITIES OUTLINE

LECTURE: FAMILY, SCHOOL, PEERS, COMMUNITY, AND YOUTH

- State the following:

  NOTE: Be sure that you have the following outline listed on newsprint.

  - Cultures, societies, and nations differ in their child-rearing practices and in the typical or traditional ways in which various social agents and peers interact with the child and youth as he or she grows into and through adolescence and on into adulthood. Nevertheless, they have in common the following: to produce adults who can carry out the roles and functions for which adults are responsible in the culture, arenas must be provided in which growth and development are fostered from infancy on.

  - In most societies the institutions most important in such growth are the family, the school, the peer group and the community.

1. *FAMILY*

   - Almost universally, families and kinship groups have served as the major arena for growth and its facilitation from childhood to at least early adolescence. Families provide models for, and training in, the emotional, social, vocational, intellectual and moral skills required for adult functioning.

   - As societies have become progressively larger, more complex and heterogeneous and less personal, other social agents and institutions have had to take over increasingly the child- and youth-related functions previously served by the family.

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	- Which functions and to what degree vary from society to society and from class to class. - Not only are more of these functions being performed outside the family but they are being assumed there at earlier ages and for longer periods. - This means that for a variety of reasons, often having more to do with expediency and adult convenience than with the welfare of the child, an increasing number of children spend most of their waking hours, and consequently most of their learning and growing, outside of the family even at very early ages. - The response of society, in this assumption of functions traditionally assigned to the family, may be unconscious, casual, routine or, in fact, responsible. In too many instances, it is inadequate, primarily because too little attention is paid to the basic psychological and emotional development so essential for maturity and for emotional, social and intellectual health. - Whatever the combination of arenas in which the child grows up, the years from infancy to adolescence are critical in all aspects of development. It is in these years that the child learns basic orientations and attitudes toward self and others: respect for, or doubt of, self, love or hate, trust or distrust and fear, growing or dying. Living is learning, particularly in these years. - Families can promote growth or retard growth by what they communicate to the child about his worth, his potential and his ability. - They also provide role models which in

turn provide goals and expectations and ways to achieve them. They provide both opportunities and expectancies for growth, the freedom and protection necessary for growth, the physical, sensory, social, emotional and intellectual nutrients for growth.

- If traditional families cannot serve these functions because of social, economic or emotional stress, some alternatives that do serve them must be developed.

2. *SCHOOL*

- In the face of all-too-human reluctance to grapple with difficult and complex problems that resonate with deeply held beliefs and attitudes, not only about drugs and drug use, but about the nature of man and of the good life, many are searching for a more comfortable and acceptable means of doing what threats of punishment and dire consequences have not seemed to accomplish.

- New hope is being placed in education both in the home and in the school, in the role of parents and teachers as individuals and of families and schools as institutions.

- From the psycho-social point of view this is filled with promise, provided it does not simply change the actors in the same old play.

- The easiest thing for schools to do is what comes naturally, what teachers have been trained to do in order to carry out the role and function assigned to the school by their culture and their community.

- These vary from society to society and from group to group.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	- In societies that have assigned the main role in socialization to the family, schools are usually assigned the role of providing information, knowledge and skills needed for use in the world of work, family and community. These tend to be substantive and subject-matter or discipline oriented. The school is also expected to reinforce, by requiring them, the "proper" ways of relating to authority and to peers; being respectful, courteous, orderly, thoughtful of others. On occasion it may be asked to deal with a problem that the family feels that it cannot deal with, for example drug use. - In societies that, for any of a variety of reasons, have assigned to the school an important role in socialization, concern goes beyond knowledge and information and involves social and personal values, areas that in the first instances are jealously guarded by the family. - In still other societies, either because they are heterogeneous or their institutions are in transition, the role of the school is not clear and may vary from community to community, from social class to social class; depending to some extent on the ability of the family to serve successfully as the socializing agent. - These are the schools that are most likely to be asked to deal with problems where all else has failed, such as drug use, and that may find it most difficult to respond in a way that is satisfactory to all. - Experience would suggest that for a school to venture beyond its assigned or accepted role into areas for which its teachers are not adequately trained

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	will be only at some risk. It might be well advised to work with parents and community to help identify the most appropriate agency to respond to the identified need. - If the decision is that the school is the most appropriate institution, it should proceed to equip itself and its teachers to deal with the problem, not assume that what it does regularly is necessarily an appropriate response. Above all, it must not claim to do what it cannot deliver. - If, in a given society, the role of the school is defined as supplying knowledge and teaching skills that are needed in the adult world, it is most unlikely that it will formally accept an active, conscious role in the personal growth and development of youth. But it actually functions in this role, often despite itself. - Schools are both formal and informal structures. On the one hand, they have assigned functions carried out by assigned individuals who perform in assigned ways. On the other hand, they are people interacting continually with other people, communicating both verbally and non-verbally, usually in the context of their assigned functions whether these are related to teaching or to learning. Teachers interact with other teachers, with administrators and with students. Students interact with other students, with teachers and occasionally with administrators. Each interaction communicates to the individual something about his status, his worth, his competence, his identity and his developmental progress.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	3. *PEER GROUPS* - Peer groups are an important factor in the growing up process. They are often treated casually but they are in reality an institution in a sociological sense. They have form and function even though both may vary from age level to age level and from place to place. - They may be created by a community or a society to serve specific functions, as in the case of scouts, youth clubs, summer camps, temporary work groups, athletic clubs, or they may be created by youth themselves in terms of their own need and be less formal and structured. - In either case they are an arena in which learning and growth occur and are especially relevant to the early task of learning to relate to a variety of people outside of the family. - They also provide a usually safe and supportive atmoshpere in which to take tentative steps toward independence and intimacy; they provide a group identity while individual identity is still developing; they provide status at a time when individual status is hard to come by for many. - It is important to remember that any group, in order to be a group and to maintain its functions, must have symbols, activities, values, behaviors that distinguish members from non-members. Manner and dress, insignia, language, music, secrets, rituals or shared experiences all serve to maintain the solidarity of the group and to proclaim its uniqueness. It is a great error to equate these group-maintaining activities with the functions the group serves. It should

also be remembered that when attacked or threatened a group may become more tightly knit and feel the need to exaggerate or flaunt the signs and symbols of its solidarity.

- Drug use may function as a sign or symbol, as an initiation rite or even as a status-giving activity. Within a group where status is gained by being tough and daring, by taking the greatest risks, drug use may provide status to the very degree that the larger society defines drugs and drug use as dangerous.

- Drug use has still other features which attract the young person to the peer group. With peers, he shares; from peers, he learns what effects to expect and recognize, what responses to make to bad effects; through peers, he obtains substances from a widespread network of dealers, sharers, users; with the drug he expects better understanding of, and interaction with, peers and better understanding of who he himself is inwardly and how he stands outwardly with them.

- Occasionally and in many parts of the world, the international commercialized youth "culture" brings increased interest in, and access to, new patterns of drug use as well as of music, dance, sociosexual interaction and modes of discovering self. These ever-changing activities, as adopted and adapted locally, may reflect traditional customs and beliefs but also always conflict with them. In this context, the latest in drug use together with music, dance, sex, self-discovery may serve as a rallying point for rebellious or bored youth seeking novel, hear-and-now identification. In keeping up with the times they learn and share with each other and have a sense of participating in a world-wide network of friends,

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performers, travellers, suppliers, hucksters, fellow-consumers. The expectation is often that these activities are ways to change mood and state of consciousness, to relate with greater feeling and empathy to others and to self--and to have fun. And for some youth the promise remains despite any number of disappointments.

- Adolescents need peer groups. They are an important part of growing up. They will thrive or persist only as long as they serve some functions related to the tasks of growing up. Early in adolescence these involve steps toward independence, exploring identity, and testing competence. Later, understanding self and others, intimacy and sharing are important. Even later, the opportunity for commitment to someone or something beyond one's self may be important.

- To the extent that other institutions cannot or do not provide these opportunities for learning and growth, the peer group will flourish. The extent to which drug use is involved may be more related to the way in which a community or a society gives meaning to and responds to drug use than to either drugs themselves or to youth. The degree to which that response relates drug use to independence, rebellion, sophistication, status, group membership may increase the attractiveness and utility of at least social use.

4. *COMMUNITIES*

- Communities are difficult to define. They may be large or small, integrated or diffuse, homogeneous or heterogeneous, formal or informal. For present purposes they will be defined as the framework within which families, schools, peer groups, and other in-

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	stitutions such as church, law enforcement, health and social agencies, and government function and which gives identity, meaning and priority to these institutions. - Community, through its institutions, defines the role and function of children and youth. It communicates care and concern or irritation and frustration. It communicates expectations, both positive and negative. It respects or denegrates. It values or ignores. It resists change or constructively accommodates change. It discriminates or values diversity. It provides for participation or it excludes. It is humane or inhumane. - All of these attitudes, feelings and actions are important influences on the nature and degree of growth and development. Just as families, schools and peer groups promote or retard growth, provide role models and define and set goals for adulthood, communities, consciously or unconsciously, provide models and define goals that are important social influences, both positive and negative, on children and youth. Communities seldom examine what they are communicating to youth. They seldom assess the adequacy with which their institutions are serving the needs of youth. But they are often all too ready to mobilize to deplore and repress the symptoms of neglect. 5. *YOUTH* - The business of youth is learning to become an adult in one's particular culture. In childhood one develops, or fails to develop, the basic feelings about self and the attitudes that will be needed in adolescence when

increasingly difficult tasks are faced. These are widely assumed to include: a sense of trust that enables the individual to take steps, explore new worlds, try new things, that is, to learn and grow; a developing sense of self as a unique, worthwhile individual with emerging talents and skills and abilities who can make things happen, have some impact on one's physical and social world; a sense of self as an individual who can accomplish things that are both personally satisfying and valued by those who make up one's expanding world.

- Without these basic attitudes and feelings, the developmental tasks of adolescence are difficult: to learn to become socially, emotionally, economically independent of family; to learn to become a person with an identity all one's own, and with a past, a present and a worthwhile or at least tolerable future; to learn to develop relationships with individuals outside of family that are satisfying and growth supporting; to learn to come to terms with one's own sexuality, to develop one's sex role in the context of one's society's definition and to develop constructive relationships with persons of both sexes; to learn to become mature enough to accept responsibility for nurturing new life and its development; to learn to find a meaning in life that transcends one's self and sustains one.
- The institutions in a society--family, school, church, peer groups, community --set the stage and provide the supporting cast.
- In earlier societies, the tasks were well defined; occupation, sex, and other roles were clear, and role models

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	were ever present and were relatively constant. Ample opportunity was afforded to acquire and practice the skills required to take the place of the adults at a future time, but in essentially the same society. Rites of passage were non-equivocal. When declared an adult, everyone, including the individual, knew that one was an adult, ready for an adult's work, and one was treated as an adult. - Many modern societies are much more complex and less stable, but the basic tasks remain the same. The explosive and rapid changes in technology, in communications, in mobility, in sheer numbers and concentrations of people, the disappearance in some socieities of the extended family, the inability to define clearly the careers appropriate in a changing world, the absence of models for these careers that do not yet exist, the heterogeneity of communities with each component struggling to maintain its integrity and that which it values--all these and many more developments have made the tasks involved in becoming an adult less well-defined, more diverse, and more difficult. Key roles in facilitating the process are shifting from institution to institution, from family to school, to peer group, to community. Each society must examine the role of its various institutions in facilitating growth from childhood to adulthood and each institution must examine its responsibility and its performance in ensuring that youth is provided with the opportunity to develop the personal, social and moral, spiritual as well as the intellectual and vocational skills necessary for life in a world adults find difficult to comprehend and youth see only in a glass darkly.

- To return to the beginning, it may be that the most important function families, schools and communities can serve is to nurture the sense of trust, the sense of worth, the sense of accomplishment and identity that will enable young people to face an uncertain future and solve the problems they face now and will face in the future.

- Most of the factors associated with destructive and deviant behaviors, including destructive drug use, can be traced through family, social, educational, and economic mazes to lack of trust, lack of sense of worth, of being valued, and lack of a sense of accomplishment and ability to accomplish tasks of value to the individual and society.

- It is not difficult to be persuaded that most of the reasons young people give for experimenting with or using drugs occasionally or even regularly--curiosity, gaining status with peers, facilitating social relationships, rebelling, increasing creativity, seeking new experience, new insights, increased sensory and aesthetic awareness, searching for meaning in life, gaining temporary relief from the pain, the anxiety, the depression that may occur in the process of learning and growing --have some relationship to the tasks involved in becoming an adult. In most societies, it would be difficult to consider any of these reasons seriously abnormal, provided no one of them was pursued obsessively and to the exclusion of others.

- Almost any young person who has failed to develop the basic trust, the sense of worth, the belief that he or she can accomplish, does not have the

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	basic tools for carrying out the tasks or solving the problems of becoming an adult. Learning is risky and hard work. The nature and extent of these problems are closely related to the way in which a society defines and relates to young people. In many cultures, especially the more highly industrialized, the adolescent role is increasingly perceived by youth themselves as one of passivity and powerlessness. This would seem to be true whether youth are excluded from significant participation in the world of work or of community via every-increasingly school-leaving ages, by early entry into an apprenticeship system or by exclusion from both. Neither passivity nor feelings of powerlessness are particularly conducive to growth. Just as childhood is a period of developing or learning skills needed for the tasks of adolescence, adolescence must be a period of elaboration of earlier skills and of new personal and social as well as intellectual and vocational skills needed for responsible and satisfying adult functioning. Maturity is not a mantle to be bestowed at whatever time is deemed appropriate; it is the product of learning and living and growing over a period of years. - Evidence would suggest that if drugs are available and if friends use or approve of the use of drugs, one manifestation of problems may be problems with drugs. Thus drug use may depend more on the environment than on the person as an individual. It is a prime example of the importance of context in the drug-individual-context interaction. - This fact poses perhaps the most vexing problem for those concerned

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	with drug abuse. Does one treat the symptom or the cause? Almost all measures directed at the causes are non-drug specific. If one is not directly attacking drug-using behavior, is one really doing anything about drug abuse? How does one know that non-drug-specific action will really have an impact on drug use? Can one afford to ignore the symptoms while treating the causes? - There is increasing willingness, particularly in countries or sections of countries where there is extensive non-medical drug use and where drug-specific responses to such use have been vigorously but not too successfully pursued, to try non-drug-specific responses. This is supported by the experience of some programs in countries such as Denmark and the Netherlands which insist that by serving youth and all their problems, they are better able to serve those with problems associated with drug use and, in the process, avoid isolating and dramatizing drug-related problems. In the many countries that have set up services designed to respond primarily to drug-related problems whether crisis centers, hot lines, or counseling centers, if these services are trusted and have demonstrated that they can be helped, they soon find that a relatively small proportion (sometimes less than 20 per cent) of their clients present drug-related problems. The majority present the more prevalent problems of youth--runaways, depression and suicide, venereal diseases, sexual problems, family problems, loneliness, and hopelessness. In some instances, they find that even adults and the elderly are turning to them. There are two interesting and contrasting

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	responses to this situation. If their sources of support and their motivation are primarily drug related, they tend to conclude that their services are no longer required and to close; if their support is general and if their concern is with drug-related problems as just one of the many problems youth face, they are not disturbed that they are asked to respond to non-drug-related problems, and they continue to serve youth as needed.
10 minutes	● Ask group members if they have questions about the material presented thus far. If so, respond accordingly.
	● Ask the group to locate in the *Resource Manual* the article entitled, *"New Directions For the National Institute on Drug Abuse"* by Dr. Robert L. DuPont, page VII-3; and the report entitled, *"Recommendations For Future Federal Activities in Drug Abuse Prevention"* by the Cabinet Committee on Drug Abuse Prevention, Treatment, and Rehabilitation, page VII-17. ● Instruct the participants to read the two articles, paying close attention to the roles of family, school, peers, and community, and to their relation to youth in prevention efforts.
30 minutes	● Inform the group that they have 30 minutes to complete the readings. ● At the end of the 30 minutes, instruct the group to stop reading.
15 minutes	SUMMARY ● State the following: - The two articles you have just read

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	indicate that the Federal government, along with the States and their citizenry, have an environment of opportunity to do something about drug abuse prevention. One of the articles states that prevention is everybody's business. - Based on the information that you have received, I would hope that you have some concern and would like to be supportive of prevention initiatives. In either case, there are roles that you can play in the drug abuse prevention efforts of this country. - In the next module, we will take some time to define some roles and develop some strategies that might have some impact on the "drug problem." END OF MODULE

REFERENCES

Nowlis, Helen. *Drugs Demystified.* Paris: Unesco Press, 1975. Chapters 5, 6, 7.

MODULE VIII

ROLES AND STRATEGIES FOR PREVENTION STRATEGIES

MODULE VIII: ROLES AND STRATEGIES FOR PREVENTION EFFORTS

PERSPECTIVE

This module provides the opportunity for participants to explore the roles of the family, community, schools, and peer groups in relationship to drug abuse preventive and habilitative processes. This is an experientially-based module that can provide some closure and direction for participants who have gone through the previous modules of this course.

This module includes:

- Overview of Module VIII (10 minutes)
- Small Group Activity: *Family, Community, Peer Group, and Schools* (45 minutes)
- Total Group Activity: *Family, Community, Peer Group, and Schools* (45 minutes)
- Lecture/Discussion/Summary: Youth's Challenge (25 minutes)

TOTAL TIME: 2 hours, 10 minutes

OBJECTIVES

1. To explore the roles of family, community, school, and peer groups in relation to drug abuse prevention efforts.
2. To explore strategies for the family, community, schools, and peer groups in relation to drug abuse prevention efforts.

MATERIALS REQUIRED

- Markers, newsprint and masking tape
- Small group and total group meeting space
- *"New Directions for the National Institute on Drug Abuse"* by Dr. Robert L. DuPont
- *Recommendations for Future Federal Activities in Drug Abuse Prevention*

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
10 minutes	OVERVIEW: MODULE VIII
	• Review the goals of Module VIII with the total group.
	• Explain the sequential flow of the module, highlighting: - Small group activities - Large group discussion
	• State the following:
	- There is an opportunity for you to explore the roles of the family, community, schools, and peer groups in relationship to preventive and habilitative processes.
	- That time is now.
	- Based on your reading of Dr. DuPont's speech and the Report of the Subcommittee on Prevention, and on knowledge that you have gained over the last few days, it is evident that something has to be done in order to reduce/prevent drug abuse in this country.
	- We are going to divide into four small groups and discuss the roles of families, communities, peer groups, and schools.
	- Group one will have the responsibility of defining the role of families and determining a strategy in relation to reducing or preventing drug abuse.
	- Group two will have the responsibility of defining the role of communities and determining a strategy in relation to reducing or preventing drug abuse.
	- Group three will have the responsibility of defining the role of peer groups and determining a strategy in relation to reducing or preventing drug abuse.
	- Group four will have the responsibility of defining the role of schools and determing a strategy in relation to

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	reducing or preventing drug abuse. - Each group should select a recorder/reporter. The reporter for each group will have the responsibility of reporting to the total group at the end of this exercise. - I will provide you with markers, tape, and newsprint to record your statements. • Ask group members if they have any questions. If so, respond accordingly. • Divide the total group into four small groups of equal size.
45 minutes	SMALL GROUP ACTIVITY: *Family, Communities, Peer Groups, Schools* • Allow the group 45 minutes to complete the task. NOTE: *Be sure that trainers are available to provide assistance. Do not try to influence the groups. Allow the groups to do their own thing.* • At the end of the 45 minute period, ask the group to stop working. • Take a 15 minute break and return to the large group.
15 minutes	BREAK *NOTE: During the break, post the newsprint with the recorded statements made by each group.*
45 minutes	TOTAL GROUP ACTIVITY • Ask each small group reporter to report to

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	the total group. Instruct each group that they will be allowed ten minutes to report to the total group. *NOTE: Trainers should not present a judgmental posture.* ● After all of the groups have reported, thank them for the work.
10 minutes	LECTURE: YOUTH'S CHALLENGE ● State the following: - In rapidly-changing societies that are becoming more diverse and more impersonal, and whose institutions are less able to respond to rapid changes, communities and nations must assess continually their role in nurturing individuals who feel they are worthwhile, are competent, are willing to face challenges, even at the risk of failure, and have a reasonable chance to accomplish the tasks their particular society defines as required for successful adulthood. - If family, school, church, community, and government do not, young people will create their own institutions, among them peer groups, that do respond to their perception of their needs; or they will resort, as individuals or as groups, to deviant and destructive behaviors. - As long as a society hides behind pharmacological agents and believes that if they could only be eliminated, all problems would be solved, the basic problems go unattended. - Until young people are supported in thinking through and working out important and meaningful identities and roles in adult society, mature social relationships, and a meaningful relation to life and to whatever God one has, attempts to cope with the "drug problem" or any other

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	disturbing behavior will be less than successful. - As long as the use of any substance, whether it be alcohol or any other drug, is serving a need, real or imagined, that is not being met in some other way, some will use it unwisely. - It is important to recognize that even if the wave of a magic wand could make all these substances disappear, something else would take their place, perhaps more acceptable, perhaps less. - As an unintended consequence, the medical profession would lose many of its most valuable means for relieving pain and treating a myriad of psychological ills. - Parents and teachers must work with, not for, young people as they identify and strive to cope with the complex problems that a few of them seek to solve or escape from with chemicals. It might help in the long run if adults set a good example. - Young people need to have understanding, sensitive adults available; they need a sympathetic and supportive area in which to struggle with the complex personal, social, and ethical problems endemic to fast-changing, increasingly-impersonal, and pluralistic societies. - If education and religion cannot meet the challenge, some other institution must. - Young people are using drugs, including alcohol, not as many of them as indiscriminate reports from visible areas and schools would tend to show, but enough of them to suggest that it may be necessary to ask some searching questions about youth, about drug use, about society and its response both to youth and to drug use, and about the

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	adequacy of institutions. - Indeed, such an inquiry may be one of the most positive steps that can be taken as a result of the concern caused by the use of drugs in present society. - Taken individually, each answer can but point to partial avenues for action. Together, however, they may constitute the framework for meaningful developments and joint efforts for the benefit of all. ● Ask group members if they have any questions. If so, respond accordingly. END OF MODULE

REFERENCES

DuPont, Robert L. "New Directions for the National Institute on Drug Abuse," presented at National Drug Abuse Conference, May, 1977.

Nowlis, Helen. *Drugs Demystified.* Paris: UNESCO, Chapter 8, 1975.

Recommendations for Future Federal Activities in Drug Abuse Prevention. Cabinet Committee on Drug Abuse Prevention, Treatment, and Rehabilitation; Report of the Subcommittee on Prevention. U. S. Department of Health, Education, and Welfare; Public Health Service; Alcohol, Drug Abuse, and Mental Health Administration; National Institute on Drug Abuse; March, 1977.

MODULE IX

CLOSURE AND EVALUATION

MODULE IX: CLOSURE AND EVALUATION

PERSPECTIVE

This module attempts to provide closure and direction for participants. They are directed to complete the evaluation forms and posttests. They are also directed to the additional training courses offered by NDAC and RSCs.

This module includes:

- Overview of Module IX (5 minutes)
- Review of Modules I through VIII (10 minutes)
- Posttest (30 minutes)
- Closure: Certificates and Departure (10 minutes)

TOTAL TIME: 1 hour

OBJECTIVES

1. To determine if participants' original goals and questions were fulfilled.
2. To recognize the additional training courses offered by the National Training System.

MATERIALS REQUIRED

- Total group meeting space
- Posttest instructions and answer sheets
- Pencils
- NDAC training program information booklet
- Certificates

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
5 minutes	OVERVIEW OF MODULE IX ● Review the goals of Module IX with the total group. ● Explain the sequential flow of the module, highlighting: - Total group activities - Post testing
10 minutes	LECTURE: REVIEW OF *FADA* Review the previous modules, giving a brief description of the facts and issues that were explored. ● State the following: *Module 1: Introduction and Orientation* provided for initial development of the training group and assisted participants in discussing training needs, expectations, and goals. *Module 2: The "Problem" with "Drugs" and "Drug Abuse"* discussed inaccurate images, exaggerated stereotypes, and unsound assumptions that can impede progress in dealing with problems associated with substance use. Particular emphasis was given to problems of perceiving and defining "drugs" and "drug abuse." *Module 3: The "Problem" with "Drug Addiction"* discussed inaccurate images and unsound assumptions that can impede progress in dealing with problems associated with drug-dependent behavior. Particular emphasis was given to vicious cycles of dependence. *Module 4: A Social and Historical Context For Understanding Substance Use in the United States* discussed the legal and social response to substance use, from the sixteenth to the twentieth century.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	Module 5: Substance Actions and Potential Hazards examined the pharmacology and potential hazards of substances. *Module 6: Understanding and Overcoming Substance Dependence* examined treatment efforts, methods, and modalities that are practiced traditionally. *Module 7: Prevention and the Community, School, Family, Peers, and Youth* focused on the prevention efforts that have been undertaken in an effort to prevent substance abuse. *Module 8: Roles and Strategies for Prevention Efforts* allowed you to explore some roles for the family, community, schools, and peer groups. *Module 9: Closure and Evaluation* means that we have come to a point of closure. We need to stop and evaluate what we have learned to this point. For some of us, it might be as far as we want or need to go; for others, there might be other directions that we wish to pursue in the areas of additional information about drugs, drug abuse prevention, drug education, drug abuse treatment, and rehabilitation. In either case, there are other courses produced by NDAC that may assist you. ● Distribute NDAC or RSC course booklet.
30 minutes	EVALUATION AND POSTTEST *NOTE: The purpose of evaluation is to obtain feedback from participants to determine effectiveness of: course content, material, procedures, and staff.* ● Explain the purpose of evaluation and posttest. ● Instruct participants to complete the evaluation forms.

TIME/MATERIALS	TRAINER ACTIVITIES OUTLINE
	• Administer posttests (See Testing Instructions in the *Trainer's Manual*, page E-3). • At the end of 30 minutes, collect the posttests. • Distribute training certificates and thank the participants. END OF MODULE

EVALUATION AND TESTS

TESTING

This section describes the development of the tests, *Form A* and *Form B*. Following the description are instructions for using the participant opinionnaires and for administering the test. Finally, the section contains the answer keys to the tests, answer sheets, and the tests themselves.

DEVELOPMENT OF THE PRETESTS AND POSTTESTS

Pretests and posttests developed for *Facts About Drug Abuse* had to meet three requirements. First, and most important, each item was to measure a specific course objective. A test meeting this condition can be used to measure the extent to which students have mastered the intended skills, attitudes, and knowledge.

A second requirement was that instruments would measure the trainees' ability:

- to interpret situations--in terms of the principles taught;
- to apply those principles to specific management situations;
- to recall the specific principles themselves.

Third, the test had to be one that could be scored objectively, quickly, and easily. There is a vast body of research literature that suggests that this requirement is virtually impossible to achieve through open-ended (free-response) items. This requirement, then, suggested some form of force-choice instrument. To meet these requirements, it was decided to design a test containing multiple choice items. The specific objective to which each item applied would be identified. Each item would also be identified as measuring knowledge at one of three levels of sophistication:

- Simple recall of material contained in the course.
- Interpretation of situations and actions in terms of principles contained in the course.
- Application of those principles to problem situations.

It was decided that one-half hour would be available for testing at the beginning and end of the course schedule, suggesting that approximately 20 items for each test could be included.

Items appropriate to each objective were written and assigned to one of the three levels of sophistication, according to the type of problem to be solved. Preliminary items were reviewed for accuracy, and to ensure that only one response was correct. Members of the National Drug Abuse Center staff reviewed the tests; based on their comments, items were revised where required. Two forms of equal length, with the same number of items, measuring each level of knowledge of each objective, were developed.

INSTRUCTIONS FOR TEST ADMINISTRATION

Either *Form A* or *Form B* can be used as a pretest, with the alternate form as a posttest. One form should be used for all participants, as the pretest, and the other as the posttest. When you administer the pretest, inquiries about test items should not be answered. It should be explained that the course will provide the answers in a way that will enable participants to understand what is correct, and, more important, why it is correct. After posttesting, feel free to discuss any and all items on either the pretest or the posttest.

Instructions should be verbalized as printed below. The time allowed to complete the test is 30 minutes.

INSTRUCTIONS

This test contains multiple choice questions. On the answer sheet darken with a pen or pencil the letter that best answers the question.

Pretraining Questionnaire*

and

Registration Form

* Note to trainer: Following are a Pretraining Questionnaire and Registration Form designed to be sent to prospective participants at least one month before training to help you determine if they need this course and to help you gear training to the participants' level.

REGISTRATION FORM

FACTS ABOUT DRUG ABUSE COURSE
PARTICIPANT INFORMATION FORM

Please complete all items:

1. Name ______________________________
   Last First Middle

2. Organization ______________________________
   Employer/Agency or Institution in which you work

3. A. Address (work) ______________________________
   No. Street City State/Zip

   B. Address (home) ______________________________
   No. Street City State/Zip

4. Work Phone ( ) ______________ Home Phone ( ) ______________
   Area Area

5. Your Position Title ______________________________

6. Years in Occupation ______________________________

7. Formal Education (check one)

   Less than High School___ High School or GED___ Some College___

   Bachelor's Degree_______ Master's Degree______ Doctorate______

   Major Field ______________________________

8. Date of Birth ______________________________

9. Training Dates __________/__________/__________
   Month(s) Date(s) Year

10. Training Site ______________________________
    Meeting Site City State

11. Training Sponsor ______________________________
    State/Local Agency

12. Trainers for this Course ______________________________
    Lead Trainer/Co-Trainer

    ____
    Co-Trainer/Facilitator

PRETRAINING QUESTIONNAIRE

DRUG & TREATMENT PROGRAM RATING SHEET

Rank these substances according to which substance you would most prefer information about. That substance you would most prefer information about should get a rating of (1). That substance which you would prefer the least information about should get a rating of (13). Do not duplicate any numbers.

Alcohol ( )
Amphetamines ( )
Cocaine ( )
DOM (STP) ( )
Heroin ( )
Inhalants ( )
Marihuana ( )
Mescaline ( )
Methadone ( )
Methaqualone ( )
PCP ( )
Psilocybin ( )
Tranqiliizers ( )
Other ( )

Rank these treatment programs according to which program you would most prefer information about. That treatment program should get a rating of (1). That treatment program which you would prefer the least information about should get a rating of (12). Do not duplicate any numbers.

Crisis intervention ( )
Group Movements ( )
Mental Health (Inpatient) ( )
Mental Health (Outpatient) ( )
Maintenance - Methadone ( )
Maintenance - Heroin ( )
Multi-Modality Treatment ( )
Narcotic Antagonists ( )
Occupational Groups ( )
Religious Groups ( )
Self-Help Groups ( )
Therapeutic Community ( )
Other ( )

TRAINER'S INSTRUCTIONS FOR SCORING THE DRUG & TREATMENT PROGRAM RATING SHEET

1. Number each participant registration sheet,
2. Insert the rating for each substance and treatment under its heading, aligned with the participant's number.
3. Add the columns and put the total in the space "TOTAL."
4. Count how many participants rated the substances.
5. Divide "TOTAL" by the number of participants, and record the result as the mean.
6. Report the ratings to all staff members involved in training the course.

SCORING SHEET
Drug Substance Ratings (1st Half)

Participant	Alcohol	Amphetamines	Cocaine	DOM(STP)	Heroin	Inhalants	Marihuana
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							
(19)							
(20)							
(21)							
(22)							
(23)							
(24)							
(25)							
(26)							
(27)							
(28)							
(29)							
(30)							
TOTAL							
Number of Objects							
MEAN							

SCORING SHEET

Drug Substance Ratings (2nd Half)

Participants	Mescaline	Methadone	Methaqualone	PCP	Psilocybin	Tranquilizers	Other
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							
(19)							
(20)							
(21)							
(22)							
(23)							
(24)							
(25)							
(26)							
(27)							
(28)							
(29)							
(30)							
TOTAL							
Number of Subjects							
MEAN							

SCORING SHEET Treatments (1st Half)

Participant	Crisis Intervention	Group Movements	Mental Health (Inpatient)	Mental Health (Outpatient)	Maintenance Methadone	Maintenance Heroin
(1)						
(2)						
(3)						
(4)						
(5)						
(6)						
(7)						
(8)						
(9)						
(10)						
(11)						
(12)						
(13)						
(14)						
(15)						
(16)						
(17)						
(18)						
(19)						
(20)						
(21)						
(22)						
(23)						
(24)						
(25)						
(26)						
(27)						
(28)						
(29)						
(30)						
TOTAL						
Number of Subjects						
MEAN						

SCORING SHEET
Treatments (2nd Half)

Participants	Multi-Modality Treatment	Narcotic Antagonists	Occupational Groups	Religious Groups	Self-Help Groups (AA)	Therapeutic Community	Other
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							
(19)							
(20)							
(21)							
(22)							
(23)							
(24)							
(25)							
(26)							
(27)							
(28)							
(29)							
(30)							
TOTAL							
Number of Subjects							
MEAN							

FORM A

1. The substance, the individual who uses it, and the social and cultural context are

    a. basic elements in the use of any drug
    b. psycho-social dimensions of drug abuse
    c. used to establish user patterns
    d. used to establish dependency ratings
    e. perspectives of drug abuse

2. The *psychosocial* perspective with regard to drug abuse puts major emphasis on the

    a. way a given society defines and responds to drug use and user
    b. substance
    c. agent, host and context
    d. individual
    e. all of the above

3. There are four major perspectives (points of view) with regard to drug use. Which perspective translates "drug, individual and context" into "agent, host and context?"

    a. moral-legal
    b. psycho-social
    c. social-cultural
    d. physical-psychological
    e. none of the above

4. Definitions of "drug abuse" are

    a. developmental and psychological in nature
    b. objective with social influences
    c. defined appropriately
    d. legal in nature
    e. often ill-defined and value-laden

5. According to the 2nd Marihuana Commission report, the term "drug abuse"

    a. has no functional utility
    b. is descriptive of behavior that, if stopped, would produce discomfort
    c. is directly related and defined by dosage
    d. is moral and legal in nature
    e. should be related to the scientific definition of drugs

6. For every drug there is a(n)

   a. lethal and toxic dose
   b. effective, lethal, and toxic dose
   c. effective, functional, and dysfunctional dose
   d. effective and toxic dosage
   e. all of the above

7. In the context of substance abuse "tolerance" refers to

   a. parental attitudes towards substance use in their community or by their children
   b. a user's ability to take heavy doses of drugs
   c. an individual's ability to mix use of narcotics, depressants, and stimulants at the same time
   d. a change in the dosage of a given drug required to produce its effects
   e. an individual's orientation toward drugs

8. The appearance of an observable abstinence syndrome after abrupt withdrawal of a drug indicates

   a. tolerance
   b. psychological dependence
   c. physical dependence
   d. antagonism
   e. potentiation

9. The reward an individual associates with things related to the drug experience, such as friendships, peer status, trendy paraphernalia, etc., involves the component of drug abuse referred to as

   a. habituation
   b. debilitation
   c. psychological dependence
   d. physical dependence
   e. drug orientation

10. The major stages leading to addiction, outlined by Van Dijk, allows for

   a. stopping practices at each stage and returning to earlier stages of drug use
   b. maintenance of family support systems
   c. psychological and physical differences in addiction
   d. the utilization of coercive motivation
   e. the utilization of supportive therapies

11. Research findings and clinical work have

    a. shown simple and basic causes which initiate the process of pathological use of drugs
    b. been minimal in the field of drug abuse
    c. isolated and validated specific common factors related to drug abuse
    d. shown one simple cause (dependency) of drug abuse
    e. made it clear that a complexity of causes and conditions give rise to the drug-taking process

12. Identify the vicious circle described by Van Dijk.

    a. Pharmacological
    b. Cerebro-Ego-Weakening
    c. Psychic
    d. Social
    e. all of the above

13. Marihuana, LSD, and STP are used as

    a. painkillers
    b. intensifiers
    c. poly-drugs
    d. stimulants
    e. depressants

14. Early public awareness regarding marihuana (circa 1930s) was:

    a. molded by several scientific studies that presented evidence to substantiate the belief that it was a dangerous mind-altering and narcotic substance.
    b. hindered by its relatively benign effects.
    c. characterized by the relative absence of research causing much speculation about its nature.
    d. responsible for the adoption of the Marihuana Tax Act of 1937.
    e. heightened by the rising frequency of marihuana-related crimes, especially rape.

15. Patent medicines were

    a. a primary source of pure opium
    b. claimed to cure "female problems"
    c. often used to quiet children and infants
    d. used mainly by women
    e. all of the above

16. The 1906 Federal Pure Food and Drug Act

a. required manufacturers to label all products containing opium, morphine, and heroin.
b. attempted to establish standards for manufacturers of tobacco and liquor.
c. appointed the first commission to attempt to classify drugs.
d. attempted to control the use and distribution of cocaine.
e. required physicians to account for morphine use.

17. The most frequently abused group of controlled substances in America today are the

a. Hallucinogens.
b. Stimulants.
c. Sedative-hypnotics.
d. Depressants.
e. Narcotics.

18. In the context of substance (drug) abuse, antagonism can be described as

a. the combined effect of two drugs being less than the effects of the drugs acting separately.
b. the joint effect of two drugs being greater than the sum of their individual effects.
c. a drug that produces negative side effects when taken with another drug.
d. any drug that causes negative side effects; it is antagonistic to the individual taking the drug.
e. any two (or more) drugs that cause the development of cross-tolerance.

19. Which one of the substances below is a hallucinogen?

a. cocaine.
b. methadone.
c. amphetamine.
d. PCP.
e. heroin.

20. Darvon^{R}, codeine, and methadone are examples of substances classified as

a. depressants.
b. hallucinogens.
c. stimulants.
d. opiates.
e. sedative-hypnotics.

21. According to Dr. Irwin's rating of intrinsic hazard potentials to the individual, which substance abuse was rated lowest?

    a. cigarette smoking.
    b. marihuana.
    c. glue sniffing.
    d. alcohol.
    e. methamphetamine.

22. The ingestion of alcohol causes a

    a. lowered tension level.
    b. heightening of the tension level.
    c. lowered tension level followed by a raised tension level.
    d. heightened tension level followed by a lowered tension level.
    e. no effect on the individual's tension level.

23. Identify the *inaccurate* statement:

    a. In 1961 and 1962, California and New York established statewide treatment programs.
    b. After the passage of the Harrison Narcotic Act of 1914, the Federal Government encouraged large cities to establish temporary clinics for maintenance and gradual withdrawal of dependent users of opiates.
    c. The explosion of drug addiction in the urban slums in the 1950s and 1960s, led to a search for more effective treatment methods.
    d. The Federal clinics at Lexington and Fort Worth were the only major opiate treatment facilities in the country until 1952.
    e. In 1964, Nyswander and Dole began an experimental drug maintenance program in New York using group psychotherapy.

24. The therapeutic community

    a. has a high (75% the first month) drop-out rate.
    b. is more efficient than other drug-free methods.
    c. mainly deals with the physical causes of addiction.
    d. is less expensive to operate than drug-free out-patient programs.
    e. is cost-effective when analyzing its success rate.

25. All of the following statements accurately describe treatment by methadone maintenance *except*:

- a. Methadone is a narcotic antagonist.
- b. It is of relatively low cost.
- c. The majority of methadone patients come from minority populations.
- d. There are numerous side effects (constipation, weight gain, numbness, and hallucinations).
- e. Methadone patients sometimes abuse other drugs such as alcohol, barbiturates, and cocaine while undergoing treatment.

26. An advantage of multi-modality treatment is

- a. it has proven useful as a special visual, auditory, and tactile prevention technique.
- b. it is the least expensive form of treatment.
- c. it is the most successful treatment for hallucinogenic users.
- d. the client has a choice among alternative treatment programs.
- e. its long-term commitment leads to a significant success rate.

27. An example of an antagonist is:

- a. methadone
- b. milk
- c. antabuse
- d. marihuana
- e. LAAM

28. Prevention based on the medical or public health model

- a. relies on the containment of known users.
- b. rests heavily on punishment.
- c. emphasizes use or non-use as human behavior.
- d. stresses the social context of behavior.
- e. relies on the family.

29. Identify the *inaccurate* statement:

- a. Families provide role models.
- b. Peer groups aid in learning to relate to a variety of people outside of the family.
- c. School provides the knowledge and skills needed for use in the world of work, family, and community.
- d. The role of communities is difficult to define.
- e. Dissemination of educational materials on drug abuse has been discriminate and applicable.

30. Of the priorities listed below, which *is not* a priority outlined by Dr. DuPont for the National Institute on Drug Abuse for the next year?

   a. Research support in investigating narcotic antagonists.
   b. The development of self-help programs for drug abusers.
   c. Providing stable funding for the majority of drug abuse treatment services.
   d. Developing a federal action plan for the nation's 8-20 year-olds to prevent dysfunctional behavior from drug use.
   e. Support legislation for the legalization of marihuana.

FORM B

1. The three basic elements in the use of any drug, licit or illicit, medical or non-medical are

   a. the substance, the individual who uses it, the social and cultural context.
   b. the dose, the tolerance of the individual who uses it, the setting, and mind set of the individual.
   c. the definition, perception, and circumstances of use.
   d. the user pattern, the environment, and the user's source of dependence.
   e. orientation, motivation, and drug classification.

2. The social-cultural perspective with regard to drug abuse puts major emphasis on the

   a. individual.
   b. substance.
   c. agent, host, and context.
   d. way a given society defines and responds to drug use and user.
   e. all of the above.

3. There are four major perspectives (points of view) with regard to drug use. Which perspective places major importance on the drug?

   a. physical-psychological
   b. disease (public health)
   c. psycho-social
   d. social-cultural
   e. moral-legal

4. An example of a problem inherent in the study of substance abuse is

   a. the perception of substance abusers.
   b. defining "substance abuse" and other terms.
   c. understanding statistical reports of substance abuse.
   d. stereotypes of substance abusers.
   e. all of the above.

5. The scientific definition of a drug

   a. is a substance that by its chemical nature, affects the structure or function of the living organism.
   b. is any substance that produces a physical withdrawal syndrome.
   c. includes medicines and over-the-counter drugs excluding illegal drugs.
   d. deals with the purposes for which substances are used.
   e. is arbitrary and a codeword for that drug use that is presently considered wrong.

6. For every drug there is a(n)

   a. toxic and lethal dose.
   b. effective, lethal, and toxic dose.
   c. functional and dysfunctional dose.
   d. physically- and psychologically-effective and physically- and psychologically-ineffective dose.
   e. medical, social, dependency dose.

7. A change in the dosage size of the drug needed to produce desired effects is an example of

   a. physical dependence.
   b. psychological dependence.
   c. addiction.
   d. tolerance.
   e. withdrawal.

8. Physical dependence

   a. is measured by the blood level of a drug compared to an apparent state of intoxification.
   b. usually develops after tolerance.
   c. is defined by appearance of an observable abstinence syndrome.
   d. is defined by the use of a drug to help the user escape from feelings such as depression or pain.
   e. is the combined physical and psychological factors that lead to addiction.

9. Psychological dependence

   a. is defined by the appearance of an abstinence syndrome.
   b. occurs mostly in times of post-war peace and affluence.
   c. is a need to experience the drug effect repeatedly even in the absence of physical effects.
   d. is usually more important than physical dependence.
   e. is a motivational stage of drug addiction characterized by increased tolerance.

10. The four major stages leading to addiction outlined by Van Dijk are

   a. contact, experimentation, excessive use, addiction.
   b. movement from the use of depressants (alcohol and tranquilizers), to barbiturates, to poly-drug use, to narcotics.
   c. experimentation, excessive use, addiction, death.
   d. experimentation, incidental use, periodic use, addiction.
   e. orientation, psychological dependence, physical dependence, addiction.

11. Of the following, which is a generating factor of drug use?

   a. the pharmacological effects of the drug
   b. personal factors of the user
   c. social meaning and value of a drug and drug-taking
   d. environmental influences on the user
   e. all of the above

12. The definition of a vicious circle is

   a. a set of circumstances that cannot be corrected.
   b. maintaining psychological patterns despite physical changes.
   c. a system that has built in biases.
   d. maintaining either psychological or physical patterns that are rationalized or denied.
   e. a cause generates a result which in its turn, maintains or reinforces the initial cause.

13. Morphine, alcohol, and heroin are used as

- a. intensifiers.
- b. painkillers.
- c. poly-drugs.
- d. stimulants.
- e. depressants.

14. The Marihuana Tax Act of 1937 was

- a. a response to a steady rise in the number of marihuana-related crimes, especially rape.
- b. based on scientific studies that proved marihuana use caused heroin addiction.
- c. passed with little or no consideration of scientific research bearing on the effects of marihuana.
- d. begun as a scheme to raise tax money to support early drug education efforts.
- e. a result of patent medicines' being put under legal sanction.

15. Largely as a result of the patent medicines, and physicians who prescribed opiate medications, _____________ became the largest class of opiate-dependent persons during the late 19th century.

- a. the elderly
- b. men
- c. children
- d. infants
- e. women

16. The Harrison Narcotic Act of 1914 was the first major federal legislation to

- a. restrict the availability of coca, cocaine, and opiates in patent medicines.
- b. outlaw the use of cocaine by minors.
- c. establish classifications of substances and a legal framework for their distribution and use.
- d. establish protection against the manufacture of stimulants.
- e. classify cocaine and marihuana as narcotics.

17. The classification sedative/hypnotic generally includes

- a. opium, cocaine, and heroin.
- b. amphetamines and barbiturates.
- c. alcohol, barbiturates, and tranquilizers.
- d. methadone and antabuse.
- e. LSD, mescaline, STP, and psilocybin.

18. Synergism refers to different situations in which

   a. the combined effect of two (or more) drugs acting simultaneously is greater than the effect of each agent added together.
   b. the effects of a drug are temporarily correlated with its administration.
   c. the joint effect of two drugs is equal to the algebraic sum of their individual effects.
   d. one drug may offset the action of the other.
   e. the combined effect of two drugs is less than the effects of the drugs acting separately.

19. Cocaine and amphetamines are examples of substances classified as

   a. narcotics.
   b. hallucinogens.
   c. barbiturates.
   d. stimulants.
   e. depressants.

20. Which one of the drugs below is classified as a synthetic narcotic?

   a. methaqualone
   b. cocaine
   c. marihuana
   d. methadone
   e. mescaline

21. According to Dr. Irwin's rating of intrinsic hazard potentials to the individual, which substance abuse was rated highest?

   a. alcohol
   b. glue sniffing
   c. barbiturates
   d. heroin and related narcotics
   e. LSD

22. A morning drink (of alcohol) after drinking all night will result in

   a. a lowered tension level.
   b. a raised tension level.
   c. a lowered tension level followed by a raised tension level.
   d. no effect on the individual's tension level.
   e. a raised tension level followed by a lowered tension level.

23. Identify the *inaccurate* statement.

a. From 1925 to 1935, treatment for drug abusers was virtually nonexistent.
b. In the late 1800s, most physicians regarded drug addiction as a physical disease.
c. In approximately 1965, researchers at Lexington began to experiment with the use of narcotic antagonists.
d. Synanon, in 1959, was the first in a line of residential treatment programs.
e. In 1952, Riverside Hospital opened a juvenile drug addiction program that showed a significant success rate.

24. Which of the forms of treatment listed below is usually/typically the most expensive?

a. hospitalization.
b. methadone maintenance.
c. multi-modality treatment.
d. crisis intervention.
e. heroin maintenance.

25. In 1964, Nyswander and Dole

a. began an experimental drug maintenance program in New York, using methadone.
b. began developing LAAM, a maintenance drug permitting dosage three times a week.
c. began using the antagonist antabuse, with alcoholics in Chicago.
d. used nalaxone successfully at Riverside Hospital in New York.
e. utilized group therapy in a residential setting for detoxification.

26. Individual treatment differences are probably best addressed by

a. behavioral treatment techniques.
b. treatment in a group psychotherapy setting.
c. treatment by family therapy.
d. multi-modality treatment.
e. individual psychotherapy.

27. An example of a narcotic antagonist is

a. antabuse
b. milk
c. nalaxone
d. LAAM
e. Darvon®

28. Prevention based on the psycho-social model

a. emphasizes use or non-use as human behavior.
b. stresses the social context of behavior.
c. relies on the containment of known users.
d. rests heavily on punishment.
e. relies on peer-group pressure.

29. Identify the *inaccurate* statement.

a. Families have served as the major arena for growth.
b. Some societies assign to the school an important role in socialization.
c. Peer groups provide a safe and supportive atmosphere in which to take tentative steps toward independence and intimacy.
d. The role of communities is difficult to define.
e. Educational materials have recently been used to generate support for social and legal action to control drugs and their uses.

30. Of the priorities listed below, which *is not* a priority outlined by Dr. DuPont for the National Institute on Drug Abuse for the next year?

a. Building a coherent Federal plan for drug abuse prevention.
b. Developing a new approach to barbiturates and other dangerous sedatives.
c. Developing a system to identify addicted probationers and parolees.
d. Addressing efforts towards female drug abuses.
e. Developing a comprehensive drug strategy for the elderly.

ANSWER SHEET

Name or I.D. Code No. ____________________
Course ____________________
Date ____________________
Instructor ____________________
Location ____________________

Check one: Pretest _____
Posttest _____

Check one: Test Form A ___
Test Form B ___

Darken with a pen or pencil the letter that best answers the question

1. A B C D E
2. A B C D E
3. A B C D E
4. A B C D E
5. A B C D E
6. A B C D E
7. A B C D E
8. A B C D E
9. A B C D E
10. A B C D E
11. A B C D E
12. A B C D E
13. A B C D E
14. A B C D E
15. A B C D E
16. A B C D E
17. A B C D E
18. A B C D E
19. A B C D E
20. A B C D E
21. A B C D E
22. A B C D E
23. A B C D E
24. A B C D E
25. A B C D E
26. A B C D E
27. A B C D E
28. A B C D E
29. A B C D E
30. A B C D E

ANSWER KEY

(Test Forms A and B)

1. ● B C D E
2. A B C ● E
3. A B C D ●
4. A B C D ●
5. ● B C D E
6. A ● C D E
7. A B C ● E
8. A B ● D E
9. A B ● D E
10. ● B C D E
11. A B C D ●
12. A B C D ●
13. A ● C D E
14. A B ● D E
15. A B C D ●
16. ● B C D E
17. A B ● D E
18. ● B C D E
19. A ● C D E
20. A B C ● E
21. A ● C D E
22. A B ● D E
23. A B C D ●
24. ● B C D E
25. ● B C D E
26. A B C ● E
27. A B ● D E
28. ● B C D E
29. A B C D ●
30. A B C D ●

PARTICIPANT OPINIONNAIRES

The sample *Participant Opinionnaires* that follow may be adapted for use at the end of each session, or modified as a feedback form for the entire course. The sample provided can be used for a unit, or a module, or the entire course.

These instruments may be used in addition to the pre- and post-tests, but will not substitute for the tests. That is, subjective assessments by trainees will not replace objective tests as an evaluative measure of trainee performance. The instruments, however, do provide at least two additional types of information: (1) The Likert-type scale (1 through 5) provides a quantitative measure of trainee reactions to various aspects of the course; and (2) the comments section provides the trainer with feedback with which he may want to make mid-course adjustments. In addition, it provides the trainee with an opportunity to express his feelings about the impact of training on him.

Be sure you have enough copies of *Forms A and B*, and Participant Opinionnaires as they are not included in the Resource Manual.

ADMINISTRATION

Either *Form A or Form B* may be used as the participants pre-test; the alternate form should be used as the post-test.

A scoring key is supplied. It should be hole-punched and then utilized to score answers.

Instructions should be verbalized as printed below. Inquiries regarding test item content should not be answered.

Time for test: 30-40 minutes. (However, allow all participants time to complete the test.)

INSTRUCTIONS

This test contains multiple-choice questions. On the answer sheet darken with a pen or pencil the letter that *best* answers the question.

FACTS ABOUT DRUG ABUSE (FADA)

PARTICIPANT OPINIONNAIRE

Instructions: Please circle a rating score for each item. *Do not* check in-between, above or below rating scores. Feel free to write any additional comment on the back of rating sheets.

Course Title ____

Training Staff ____

Name ____

Role (check one) Participant _____ Staff _____

Directions: Please rate the following areas using the scales below. Draw a circle around the rating score for each item.

CONTENT

Rate the *lecture* (presentation content).

(A) Utility	1 useless	2 marginal	3 useful	4 very useful	5 exceptionally useful
(B) Interest	1 dull	2 unstimulating	3 interesting	4 very interesting	5 exceptionally interesting
(C) Level	1 simple or too difficult	2 easy or difficult	3 average	4 balanced	5 balanced and challenging at times

Rate the *Resource material* (Resource Manual).

(A) Utility	1 useless	2 marginal	3 useful	4 very useful	5 exceptionally useful
(B) Interest	1 dull	2 unstimulating	3 interesting	4 very intersting	5 exceptionally interesting
(C) Level	1 simple or too difficult	2 easy or difficult	3 average	4 balanced	5 balanced and challenging at times

Rate the *supplementary material* (transparencies, films, charts, etc.).

(A) Utility	1 useless	2 marginal	3 useful	4 very useful	5 exceptionally useful
(B) Interest	1 dull	2 unstimulating	3 interesting	4 very interesting	5 exceptionally interesting
(C) Level	1 simple or too difficult	2 easy or difficult	3 average	4 balanced	5 balanced and challenging at times

Comments: What additional areas do you feel should have been explored? Any additional comments on material you like or disliked?

METHODS

Rate the *large group presentations.*

		1	2	3	4	5
(A)	Objectives	inappropriate	misleading	accurate	very accurate	exceptionally accurate
(B)	Design	counter-productive	wasteful	economic	very effective	high yield
(C)	Acceptability	offensive	tolerable	acceptable to most	very desirable	high involvement

Rate the *small group processes.*

		1	2	3	4	5
(A)	Objectives	confusing	misleading	accurate	very accurate	exceptionally accurate
(B)	Design	counter-productive	wasteful	economic	very effective	high yield
(C)	Acceptability	offensive	tolerable	acceptable to most	very desirable	high involvement

Comments: What changes would have helped you/others learn better?

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OBJECTIVES (continued)

- identify at least three of the "vicious cycles" related to drug addiction;
- identify at least three factors leading to the development of a dependent substance user pattern related to the painkilling function of substances (drugs);
- identify at least three factors leading to the development of dependent substance user pattern related to the social-recreational functions of substances (drugs);
- identify at least three major events that led to the development of the "intensifying" use of substance during the 1960s;
- identify one social and one legal response to substance abuse post-Civil War;
- identify one social and one legal response to the use of alcohol;
- identify at least three changes, since 1965, in social and legal responses to substance abuse;
- identify at least four perspectives drawn from history that represent consequences of the drug laws on certain groups;
- identify the difference of withdrawal syndromes related to heroin and alcohol;
- identify at least three commonalities related to heroin and alcohol.

AUDIENCE

This course is designed to train drug abuse prevention and treatment workers (or their direct supervisors), teachers, guidance counselors, drug educators, school psychologists, PTA/PTD members, recreation workers, youth workers, peer counselors, gang workers, youth employment counselors, parole and probation officers, outreach workers, hot-line workers, people working with youth overseas, military personnel, and community service organizations.

CONTENT

Module I: Introduction and Orientation

Module II: The "Problem" with "Drugs" and "Drug Abuse"

Module III: The "Problem" with "Drug Addiction"

Module IV: A Social and Historical Context for Understanding Substance Use in the United States

Module V: Substance Actions and Potential Hazards

Module VI: Understanding and Overcoming Substance Dependence

Module VII: Prevention and the Community, School, Family, Peers, and Youth

Module VIII: Roles and Strategies for Prevention

Module IX: Closure and Evaluation

METHODOLOGY

Lectures, mediated demonstrations, guided group discussions, task group exercises, and individual reading assignments.

TIME REQUIREMENTS

Total training time is 28 hours, plus six hours of individual reading assignments.